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**The Competing Demands for Women's Labor: the Role of
Women in Long-Term Care Provision in the Russian
Federation**

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The Competing Demands for Women's Labor: the Role of Women in Long-Term Care Provision in the Russian Federation

This report focuses on demographic trends within Russia, in order to assess women's participation in the labor force and how this may be affected by the increasing demand for long-term care. The report identifies the vital role of Russian women in providing both formal and informal long-term care. This first section places the topic in context, noting that migration to Russia is declining and is not likely to compensate for population losses and the aging of the population.

1. Introduction

Populations have been aging rapidly in the majority of the developed world; moreover, it is predicted that by 2010 overall populations will start decreasing in countries such as France, Italy, and Japan. In 2004, more than half of the world's older old lived in just six countries: China, the United States, India, Japan, Germany and Russia (Kinsella and Phillips 2005). At the same time, the unique conjunction of rapidly aging and relatively poor populations exists particularly in Russia. Russia will experience demographic transition as part of global demographic changes toward longer life expectancy and lower fertility but may be less equipped economically to address the multiple implications of such changes. Russia will also observe the fastest aging of its population over the next two decades due to unprecedented declines in fertility and rising life expectancies. Based on 2000 data, it is estimated that by 2025 the Russian population will shrink by 17.3 millions (Chawla et al 2007). This population will contain many older people, both in absolute numbers and proportionally.

The other major difference in Russia from more industrialized aging countries, arises from the unprecedented interaction of the demographic transition to an aging society with comprehensive economic and political transitions still under way. It is the interaction of the three transitions that makes the region unique. Reform in the former Soviet countries has generally been slow. At the same time, the death toll in recent years has been particularly high for working-age males (United Nations 2008). The political and economic collapse of the former Soviet Union undermined public health and led to severe declines in life expectancy, especially for Russian men.

As highlighted by several World Bank publications (2003, 2005 and 2007); the increase in mortality rates during the last two decades in Russia has several long-term implications in terms of demographic and socio economic changes. Since the early 1990s the Russian population has been shrinking in numbers, with average annual population growth in the years 1990-2003 of -0.3 percent. Moreover, some increases in life expectancy hide a number of years of ill health and disability.

Russian women live approximately 14 years longer than Russian men, with female life expectancy of 72 years in 2008. The longevity gap is significantly wider than in other G8 countries, where it ranges between 5 and 7 years. Between 1987 and 1994, life expectancy at birth for Russian males dropped by 7.3 years to reach 57.6 years and has not yet fully recovered. These large gender differences in Russia suggests that specific behavioral factors are implicated, rather than factors simply related to the external environment or adequacy of health care, which affect men and women to somewhat similar degrees. Two major factors behind this large gender gap are smoking and alcohol consumption, as these behaviors are vary considerably between men and women, even those living in the same households (Brainerd and Cutler 2005). Nonetheless, although Russian women out-live Russian men, they are generally in worse health than other women in Eastern and Western Europe.

Currently the Russian population structure is characterized by a shrinking proportion of young people and an expanding proportion of people aged 60 years and above. Contributing to this phenomenon are sustained very low levels of fertility during the last two decades compared to previously higher fertility levels that produced comparatively larger cohorts. Two decades ago, young people aged 0-14 years constituted about a quarter of the Russian population, and those aged 60 years and above made up 14 percent of the total. Currently, those aged 0-14 have dropped to 18 percent. With the Russian expected total fertility rates of between 1.1 and 1.3 children per woman of reproductive age for the years 2005-25, projections suggest that those aged 0-14 will remain at about 13 percent of the population, and population growth rates will remain negative, averaging between -0.6 and -0.8 percent. As a result, the proportion of people aged 60 and over will become more than a quarter of the total of the population.

The percentage of the working-age population in Russia (males 16-59 years, females 16-54 years) has increased slightly, from 59.3 percent in 2000 to 63.6 percent in 2007, but is estimated to decline to 59.7 percent by 2016. During the same period, the structure of the working-age population will undergo significant changes where the share of the population aged 45 and more within the total working-age population will increase from 25.7 percent at the beginning of the 2000 to 30 percent in 2016. We explain later that this age group is also particularly likely to have family caring responsibilities.

Population Migration

Since 1992 the net migration of people from other countries (mainly from the Commonwealth of Independent States countries and the Baltic countries) has constrained the decrease of the population of Russia. As a whole for 1992-1999 migration compensated for population loss by a half. However, in 2000 net migration almost halved as compared to 1998 (from 284.7 thousand people to 154.6 thousand people) due to the sharp decline of the number of people arriving to Russia while net migration compensated only for 16.7 percent of the natural loss of the population.

Statistics on migration patterns in Russia show that migration's role in its population dynamics has recently been important, but its role in offsetting the negative growth in population size has been of significance only for limited periods in the past 25 years. Prior to 1992, migration was relatively low, averaging less than 130,000 persons between 1985 and 1992. The transition years experienced a very rapid increase in population migration, such that net migration increased rapidly from about 176,000 persons in 1992 to a peak of 800,000 persons in 1994 and remained at levels slightly above those of pre-transitional years until about 1999. The largest migration exchange is still observed between Russia and the former republics of the USSR. Annually, about 95 per cent of those arriving and 60 percent of those leaving relate to these countries.

Purpose of this report

This picture of an ageing population with potentially many years of ill health and shrinking working age groups combined with significant difference in mortality by gender places the Russian Federation in a particularly difficult position in addressing the long-term care needs of its aging population. This report focuses on understanding the unique role of women within this context, as women are traditionally and currently the main informal care providers to family members and in local communities. Moreover, with the shrinking working age population women's labor participation becomes more necessary and this may directly compete with other care demands. The longer life expectancy of women than men, and the high possibility that many of these years of later life will be characterized by ill health and disability, place women, in particular, in a vulnerable position during later life.

The report focuses on the demographic trends of the Russian female population, their historical and projected labor force participation and how these are anticipated to interact with the increasing demand for long-term care. The report also addresses the vital role of Russian women in providing both formal and informal long-term care. Evidence from various government policies and strategies in addressing the growing costs of long-term care is drawn from a review of policies and research concerning other European countries as well as Japan, the United States and Australia. A review of other developed countries describes existing strategies used by women to balance their increasing and competing multiple roles and considers whether there are government policies adopted by other developed countries that aim to reduce such burden and remove some of the barriers that are faced by women to equality of opportunities. Further, the report illustrates some existing policies, drawn from OECD countries, to provide support to and/or financial compensation for loss of income and entitlements to informal carers.

2. Projected demographic trends for the size of the Russian female population at different ages

This section of the report outlines population projections, noting the likely rise in numbers and proportions of the older population in Russia. The gender gap in life expectancy is highlighted. Among a number of effects, this means that as many as six out of ten women aged 65 and over are widows. Regional differences in life expectancy are also sizeable. Changes in family patterns, lower fertility rates, high divorce and high widowhood rates reveal the risks of relying on informal care to support people in later life. Population projections show that the potential labor supply is unlikely to meet the needs of the economy and of growing older age groups, unless labor force participation is expanded among older age groups. The dual challenge is to ensure that additional years of later life are lived in good health to reduce demand for long-term care and to provide good quality of life, and that female labor participation rates are maximized without undue stress for women. This review uses published statistics as well as data obtained directly from the Generation and Gender Program.

Global projections to 2030 suggest that 11 countries are expected to lose at least 1 million people in the size of their populations. Russia is at the top of the list with a projected decline of 12 million, followed by Japan with 11 million (Kinsella and Phillips 2005). According to different forecasting scenarios (Vishnevskiy et al 2007); the percentage of people aged 60 or more in Russia will increase from 21.5 percent in 2002 to 32 to 36 percent of total population in 2050.

In 2008, Russian female life expectancy (72 years) remains similar to the level of 1995; while male life expectancy is 59 years, four years less than that in 1995. Until 2004, declines in life expectancy in Russia contrasted with strong growth in Gross National Income (GNI) since 1998 (Source: World Bank World Development Indicators 2005/ WHO 2003). In 2006 average life expectancy in Russia rebounded to 66 years (the same level of 2000), this is compared to an average of 78 years in the European Union. In terms of Healthy Life Expectancy (HLE), in Russia, HLE for women is about 10 years less than in France and 16 years less for men than in the United Kingdom.

Moreover, mortality rates and life expectancy at birth in Russia vary greatly by region (Rosstat 2007), partly because of regional socioeconomic differences (Chawla et al 2007). The mortality rate of the economically active male population from region to region ranges from 3.8 to 17.8 deaths per 100,000 people. Data for 2001 show that people in regions such as the Republics of Ingushetia & Dagestan and in Moscow have the longest life expectancy and live 18 years longer than those in low-income regions such as Republic of Tyva, Koryak Autonomous Okrug, and Komi-Perm Autonomous Okrug (World Bank 2005). Uneven fertility, mortality, population growth, and life expectancy in different regions and among social and ethnic groups may exacerbate existing variations (World Bank 2005). Moreover, large numbers of deaths, which are

driving down life expectancy rates, are occurring among working age groups, particularly men, with the highest causes of death being from cardiovascular diseases and injuries.

The pattern of fluctuating life expectancy in Russia is very much associated with political, economic and social policy transitions in the country. In early 1960s, life expectancy at birth in the former Soviet Union was nearly the same as that of the United States at around 62 years for men and 71 years for women. After this period life expectancy at birth remained almost constant until mid 1980 followed by a slight increase; it then started to decline in the 1990s (Human Development Report 2005). Putting these trends in the Russian context, the slight improvements in life expectancy observed during the mid 80s were largely associated with the Gorbachev anti-alcohol campaign (1985-87), but the effect of this public health initiative seemed to diminish after the end of this campaign. The dramatic deterioration in life expectancy observed since the 1990s, particularly up until 1994, has been associated with the transition to a market economy. Following a slight improvement up to 1998, male life expectancy started to fall steadily after the 1998 financial crisis (World Bank 2005). Moreover, data on the life expectancy at birth hide some more dramatic statistics concerning Russian men.

Gender differences in life expectancy occur throughout the world, however, to much lower extent than that observed in Russia. Women generally enjoy longer lives than men for a number of biological and socio-economic reasons. In 2002, women in the United Kingdom lived 5.1 years longer than men; women in France lived 7.5 years longer; and women in Japan lived nearly 7 years longer. However, the literature and demographic trends show that Russian women outlive men by approximately 14 years, almost twice the largest difference elsewhere. With the large decline of men in working age groups, increased pressure is anticipated for women to participate in the labor market. Moreover, the gender gap in life expectancy has led to shorter lengths of marriage partnerships and an extremely high proportion of widows in Russia, for example, in 2002 the percentage of widows in Russia aged 30-44 is 3.6 times more than that in the United States (see Table 2.1).

Table 2.1. Percent of widows in Russia (2002) and U.S. (2000) population

Age	Males		Females	
	Russia	US	Russia	US
20-24	0.0	0.2	0.3	0.2
25-29	0.1	0.2	1.1	0.3
30-34	0.3	0.3	2.2	0.6
35-44	0.9	0.5	4.8	1.3
45-54	2.4	1.0	11.1	3.7
55-64	7.0	2.8	28.0	11.9
65+	19.5	13.9	59.1	45.3

Source: 2000 Census of Population and Housing, Summary Population and Housing Characteristics, U.S. Census Bureau, Washington, DC, 2002. Results of the All-Russia population census 2002. Age-sex structure and marital status. Moscow. 2004.

During the transition years of the 1990s, the escalation of mortality rates affected both Russian men and women, but the size of the effect was greater for men: they lost 5 years of life expectancy between 1990 and 1994 while Russian women lost 2, keeping the gender gap in life expectancy at about 13 years. Recovery of life expectancy post-1995 has been slow for both men and women. In 2003, male life expectancy was only 58 years and that for females was 72 years. The gender gap in life expectancy is expected to persist in the coming years. As a result of the gender gap in mortality, the 2002 all Russian population census showed that the sex ratio decreased after 1989 (the number of men per 1,000 women fell from 877 in 1989 to 872 in 2002) (Andreev 2005). Furthermore, projections for the next 25 years indicate that although Russia will experience improvements in life expectancy the levels will remain below those expected for Russia's G8 partners.

Maternal mortality in Russia is also a cause of concern, the estimated maternal mortality ratio (the number of maternal deaths during a given period per 100,000 live births during the same period) in Russia was 31.3 in 2003, approximately six times the average ratio for European Union countries of 4.9 (UNDP 2005). It is estimated that 70 percent of maternal deaths are avoidable and measures need to be adopted to address the leading causes of death, such as post-partum hemorrhage and sepsis after delivery (Sakevich 2005). Similarly, the World Bank report (2005) observes that Russian women are more at risk of dying from abortion procedures than women elsewhere in Europe and Central Asia. Abortions accounted for 16 percent of Russian maternal deaths in 2003, with the leading cause of death being post-abortion infections. Unlike other countries, where deaths due to the consequences of abortion performed outside medical institutions after 12 weeks of gestation involve predominantly young or unmarried women, half of the women who died in Russia were aged 30 to 40 years and have had previous pregnancies (Zhironova et al. 2004). The leading cause of death was post-abortion infections (in 80 percent of cases). In 2003, there were 45 abortions per thousand women aged 15-44 in Russia compared to 13 in Japan and only 7 in Switzerland (Alan Guttmacher Institute 2007).

It is important to understand the reasons behind such high abortion rates in usually safe circumstances and whether these are due to lack of awareness of or lack of availability of modern contraceptive methods. David and colleagues (2000) show a relationship between the increase use of modern contraceptives (mainly IUD and pills) and a reduction in the prevalence of abortion among Russian women age 15-49 from 1988 and 1997, and they strongly suggest that awareness and availability of contraceptives will play crucial roles in the reduction of abortion rates.

Another important aspect of these changes is the associated shifts in family formation and structure. Blum and Lefèvre (2006) document the rapid changes in the Russian family structure from those observed during the Soviet era. During the last few years of the Soviet Union, age at first marriage was decreasing while it increased almost everywhere else in Europe. Co-residence with parents or in-laws was also widespread; this was also simultaneously associated with high divorce rates among young couples which were usually

attributed to the birth of first child or termination of pregnancy through abortion, where the use of contraception was usually not recommended before the first birth (Vichnievski 2006).

Since the early 1990s, these characteristics of early marriage, co-residence and early divorce underwent some changes. While in 1989 around 80 percent of Russian women aged 25-29 were married, this declined to 65 percent in 2002 (Census data). In addition to a general decline in age at first marriage, there was also a trend of increasing divorce rates. Total divorce rates increased from 0.425 in 1980 to 0.503 in 1995, while the mean age of women at divorce dropped from 33.6 years in 1980 to 32.5 in 1995 (Avdeen and Monnier 2000).

Changes in social policy were associated with these shifts in marriage patterns. First, there was an increase emphasis on educational attainment; also housing policies changed and marriage was no longer a pre-requisite for allocation of housing. Changes in marriage and family formation were also associated with and followed by declining fertility trends and an increase in maternal average age at first birth. In Russian circumstances, the smaller number of children in a family may be linked to increased economic pressures and financial insecurity rather than an autonomous choice (Blum and Lefèvre 2006).

The various economic, social and political changes in Russia explain some of the observed decline in fertility rates. Economic crises and uncertainty about the future directly increase the costs of bearing and rearing a child. It is also apparent that the political transition towards more western practices changed some perceptions around family formation and childbearing. And last, but not least, was the shift from the Soviet pro-natalist policies in the early 1980s where benefits were available to women who gave birth to a third child and who were offered nearly 3 years maternity leave. Changes in family formation patterns, lower fertility rates, higher divorce and widowhood rates as well as large gender gap in life expectancy all indicate that the population will be less able to rely on family or informal care in their old age.

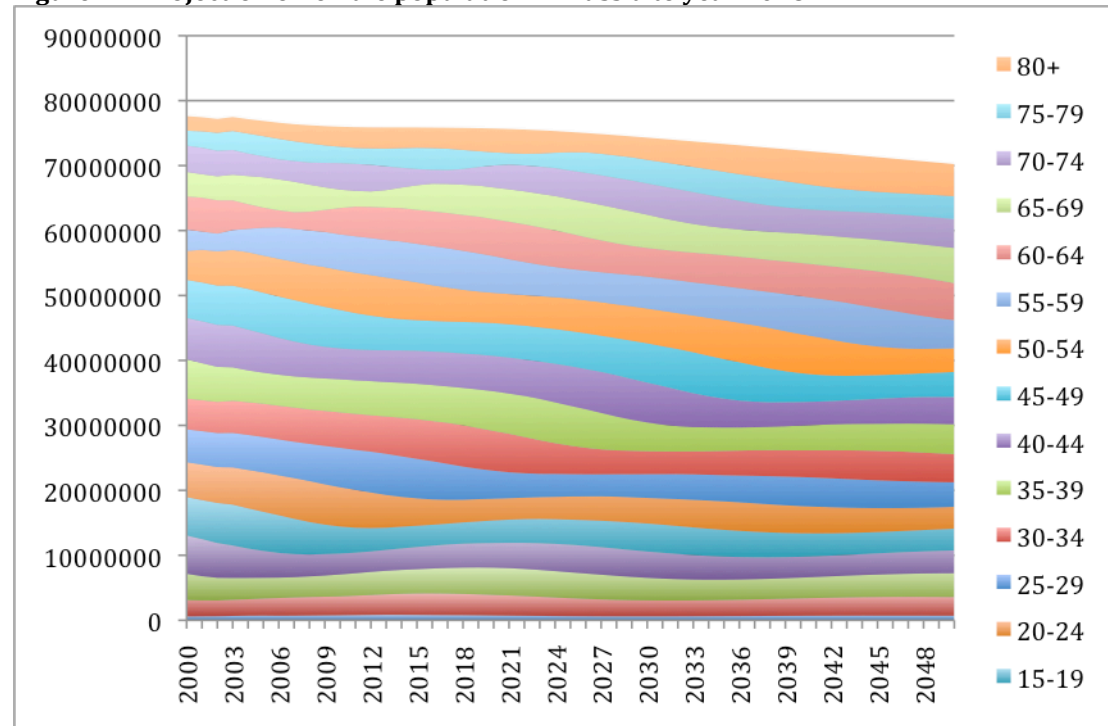
What is the potential supply in Russia of labor for the next 30 years?

Using data obtained via the Generation and Gender Programme (<http://www.unece.org/pau/ggp>), Figure 2.1 presents the projected female population by age group from 2000 to 2050. The data show that in total the overall absolute number of women is predicted to shrink; as is the case with the Russian population as a whole. However, after some fluctuation it is projected that the number of women aged 80 or more will be larger than those in the age group 50-54 by the year 2050.

As a general rule, the terms labor force and the economically active population are usually employed interchangeably in most research. Technically, however, there are some minor differences. The International Labor Organization (ILO) defines the economically active population as 'all persons of either sex who furnish the supply of labor for the production of economic goods and services as

defined by the United Nations systems of national accounts and balances during a specified time-reference period' (Farooq and Yaw, 1992). The labor force, by contrast, includes those people of official working ages that are economically active (16-54 for women and 16-59 for men), which excludes people younger or older than the accepted age limits for the formal workforce.

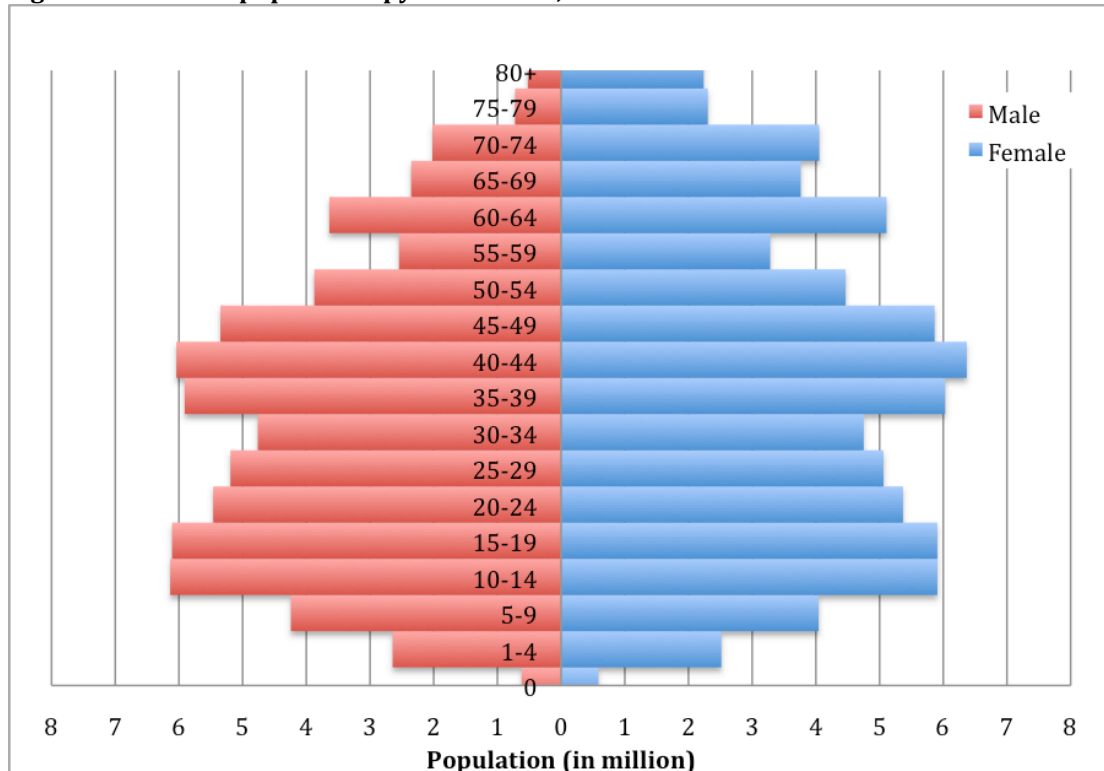
Figure 2.1 Projection of female population in Russia to year 2048



Figures 2.2 and 2.3 present the Russian population structure in 2000 and population projections for 2050. Population projections for the total population of Russia, presented in these two graphs, were constructed using cohort component methods and Generation and Gender data. Examining the Russian population pyramid in 2000 and its projection, the number of people age 80 or more were mainly women in 2000, and this gender gap is predicted to dramatically increase by 2050.

The 2000 population pyramid (Figure 2.2) shows the sudden drop in fertility rates following the dissolution of the Soviet Union. We can also see the small working age group, 30-34 in 2000, which was associated with World War II, as well as the small older age group, 55-59 in 2000, associated with the famine and Stalinist eliminations of the 1930s, when malnutrition and fear sharply affected birth rates. All these changes directly affect the potential labor force. Although fewer people are in the very young cohorts, larger groups (age 10-19 in 2000) will be entering the workforce with almost similar numbers of females and males, and a peak of absolute size of working-age population is predicted for 2009-2010, after that, the number of potential working age groups is predicted to decline rapidly.

Figure 2.2 Russian population-pyramid 2000, Generation and Gender Data



Officially, the working-age population in Russia is defined as all males between the ages of 16 and 59, and all females between the ages of 16 and 54. Due to high rates of participation in the labor force among the older population, statistical agencies in Russia adopt an operational definition of the working-age population as everyone between the ages of 15 and 72, and references to the potential labor force usually mean this age range (Donahue 2004). The labor force itself is defined as any individual engaged in productive work for pay, or seeking such work, regardless of their age. By 2050, the population in the traditional working age-groups (16-59) is predicted to be smaller than those younger or older put together, or traditional 'dependant' groups (see Figure 2.3). With increased longevity, particularly among women, female participation rates are predicted to increase and to continue into older ages.

Figure 2.3 Projected Russian population-pyramid 2050, Generation and Gender Data

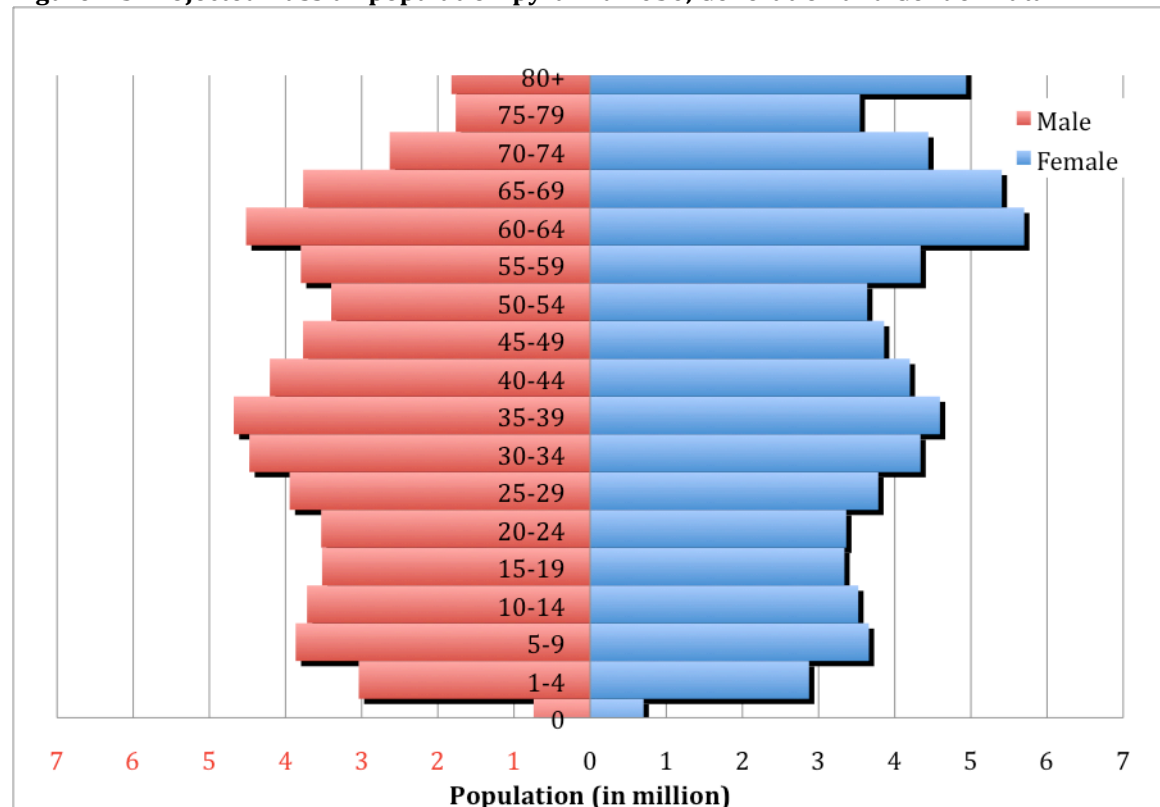


Table 2.2 shows that total dependency ratio is predicted to increase from 63.9 in 2002 to 123.1 in 2050, with the majority of this increase attributed to that of the older population ratio. The projected dependency ratio of 123.1 in 2050 means that there will be more people outside the official working age group than that inside it.

Table 2.2 Russian Working-Age Population and Dependency Ratios: 1989 - 2050

Year	Working age population	Youth dependency ratio	Older population ratio	Total dependency ratio
1989	83,982,651	43	32.5	75.5
2002	88,585,537	29.7	34.1	63.9
2010	87,550,889	24.5	36.1	60.6
2020	76,071,588	28.7	49.6	78.3
2030	70,295,695	26.4	57.4	83.8
2040	61,532,578	27.4	71.5	98.9
2050	51,595,532	32.7	90.4	123.1

Note: Retirement ages in Russia are 55 for women and 60 for men.

Working Age: 16-54 for women and 16-59 for men

Youth Dependency Ratio: population 0 to 15 per 100 working age population

Older Population: Population over retirement age per 100 working age population

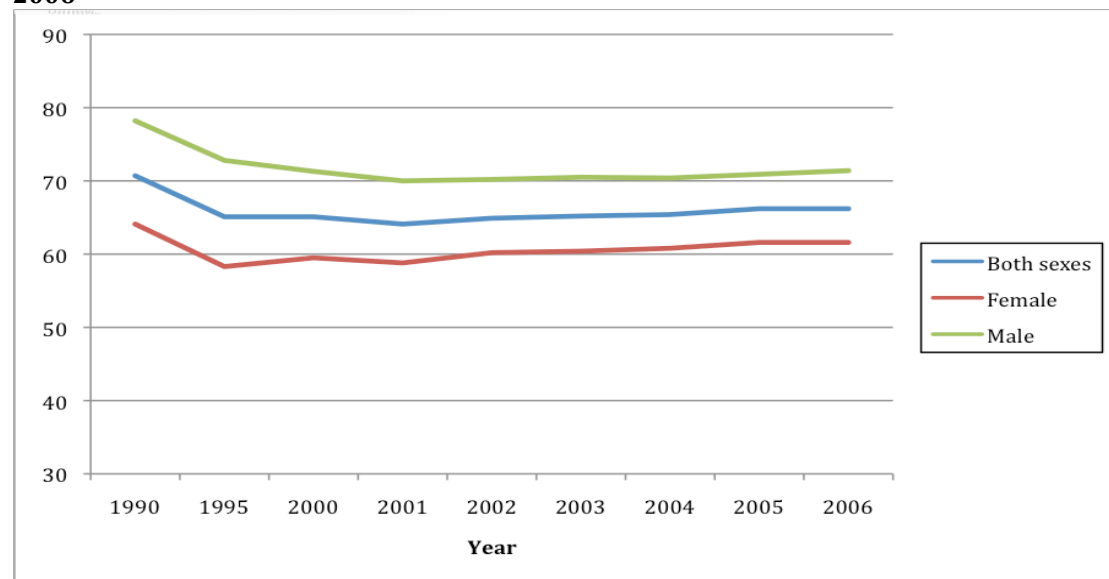
Source: Projections performed at International Programs Center, U.S. Census Bureau.

Russian population projections clearly show that the pension system as it stands is unsustainable. In terms of economic activity rates among the population, Russia enjoys an overall high rate with relatively small, but consistent, gender gaps. Using Generation and Gender data, Figure 2.4 shows such rates and that

those among women have been consistently lower than those among men since 1990 to 2006. However, these crude small differences hide further gender inequalities in labor participation, both in terms of quantity and quality, among women and men, which will be discussed in detail in the next section. Unemployment was perceived by some to have been an 'ideological impossibility' during the Soviet period (Donhanue 2004, Fullsack 2001, Standing 1999), and many labor experts predicted a sharp increase in employment rates in the early 1990 with the introduction of the free economic market. These prediction did not occur in reality, moreover, it became evident that it was getting harder for unemployed people to gain employment.

Using Generation and Gender Survey data, long-term unemployment rates are calculated as the percentage of people who are unemployed for 12 months or more out of the total unemployed population and are presented in Figure 2.5. These data show an initial increase in long-term unemployment which has since levelled off to around the 40 percent mark. This is indeed much higher than the 10 percent observed in the early 1990s. Not surprisingly both Figures 2.4 and 2.5 show that women were affected more by unemployment than men and labor participation rates have been consistantly lower among women while long-term unemployment rates are consistantly higher among women than men. However, gender differences in long-term unemployment are much smaller than those observed in relation to labor force participation rates.

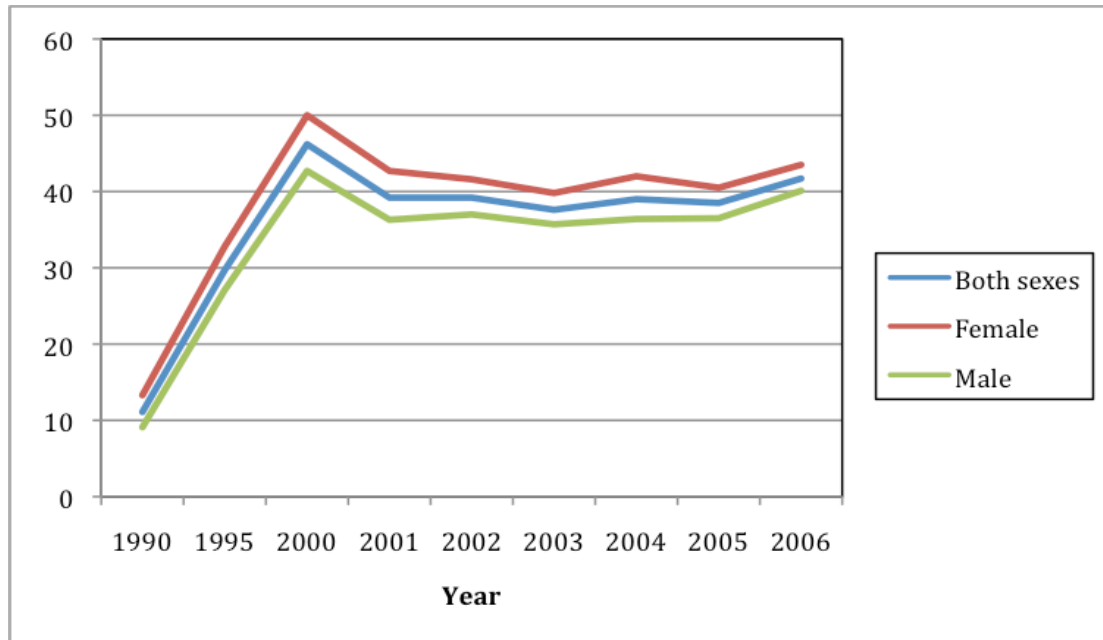
Figure 2.4 Economic activity rates by gender, Generation and Gender Data Russia 1990-2006



Population projections clearly show that the potential labor supply is unlikely to meet the needs of growing older age groups, unless labor force participation is expanded among older age groups, providing that additional years are lived in good health, and female labor participation rates are maximized. However, with a parallel growing demand on women to provide informal care, Russian women are faced with an increasingly complex set of expectations. In the next section we

review historical female labor participation in Russia and explore further possible explanations of the gendered nature of labor market participation.

Figure 2.5 Long-term unemployment rates by gender, Generation and Gender Data, Russia 1990-2006



3. Labor force participation rates among Russian women

This section explores the historical context of women's labor participation in Russia, where there has been a long tradition of official support for working women. It highlights the scale of the potential unused female labor force in Russia, among skilled and unskilled women, and the need to find effective policies to facilitate and maintain women's labor participation in Russia. The decline in employment of older people in Russia is noted. The percentage of working age group 15-59 in the population compared to other age groups is likely to fall considerably, depending on different fertility assumptions. From the different projections and scenarios presented in this section, it is apparent that Russia needs to make the most of its population, in terms of maximizing labor participation rates for both men and women and for those in different age groups, particularly 'older' workers.

In any society, women's labor force participation is restricted by many obstacles: lack of education, discrimination in wage rates and employment practices, negative cultural attitudes and obligations to provide informal care for both children and older family members. Historically, in Russia, gender equality in education has not been considered to be a significant issue. Russian women equaled and even surpassed men in average educational attainment in the 1970s (Gerber and Hout 1995), however women were concentrated in less lucrative fields of study (Gerber and Schaefer 2004). Therefore, women and men with perhaps similar levels of education may differ systematically in their specific skills and this may partially explain the wide gaps in the wages of men and women, observed in Russia, similar to those in Nepal, Bangladesh and Pakistan (Cockburn et al 2007).

The roots of labor participation gender equality regulations in the former Russian Federation lie in the Bolshevik program of the early 20th century, which emphasized the need to transform economic relationships and ensure women's economic well-being (Aivazova 2001). Increased women labor participation was centrally organized and occurred during the period of rapid industrialization of the 1920s and 1930s. During the Soviet era the gender employment gap was comparable to levels found in other developed societies (Brainerd 2000). For example, in the former Soviet Union female participation rates were regularly over 85 percent, while in Europe rates of this kind have only recently been observed in some Scandinavian countries. It is commonly argued that Soviet ideals and chronic labor shortages pushed women into the labor force during this era. In addition, universal state schemes for childcare and maternity leave assisted levels of women's participation in the labor market to nearly the same rate as men. However, job segregation by gender and the concentration of female labor participation in low-skilled job resulted in women generally earning less than men, by around 70 percent (Ogloblin 1999 and Flakierski 1993). Historically, due to the narrow Soviet wage distribution pattern, lower gender-gaps in absolute wages occurred prior to 1992 (Flakierski 1993).

Generation and Gender Survey data confirm that Russia has not experienced unemployment as such until the beginning of the 1990s. An unemployed person used to be a rare individual from a marginalized group. However, unemployment became evident from the beginning of the 1990s. Since 1989, with the collapse of the Soviet Union, women's labor participation rates started to fall in Russia and many other transitional economies (UNICEF, 1999). In a comparative analysis of employment and gender-role attitudes between Russia and Sweden, Motiejunaite and Kravchenko (2008) observe that although both countries facilitate the 'dual-earner' family model, Sweden places a greater emphasis on dual-caring and flexible work arrangements for both men and women. Russia, on the other hand, supports traditional gender roles suggesting that although female employment is facilitated and encouraged, traditional domestic gender-role attitudes remain. Using International Social Survey Program (ISSP) data on the 'Family and Changing Gender Roles', Rounds II (1994) and III (2002), Motiejunaite and Kravchenko conclude that public social policy is significant in regulating not only women's employment patterns but also their gender-role practices and attitudes.

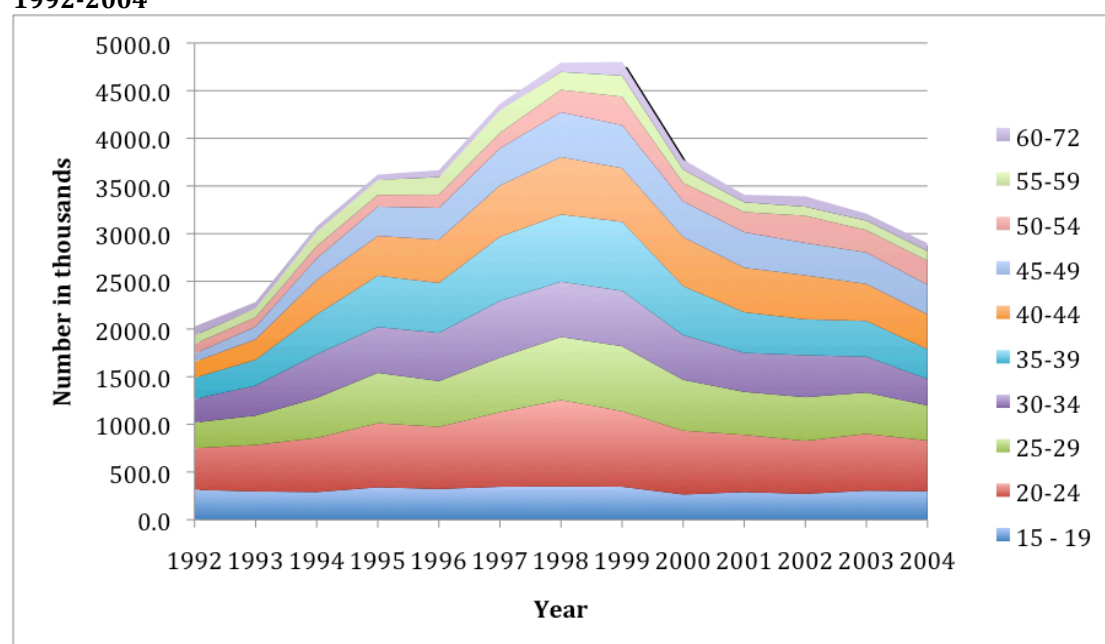
The claim to sexual equality in the public sphere, once central to so much of Soviet policy and ideology with regard to women and their 'liberation', appears to have been reversed over the decade following the Soviet Union's demise. Based on data collected from 1993 to 1997 on women's experiences of employment, Kay (2002) observes how political and economic changes produced a shift in the balance between women's responsibilities in the public and private spheres of paid employment and domestic life respectively. An extensive analysis of gender inequalities in Russia (UN 2005) further highlights the unequal positions of men and women in the economy, in terms of human capital return and unequal access to economic resources as well as traditional labor and domestic role divisions.

In January 1992 the Russian government introduced extensive market reforms. These included removing most controls on prices, wages, trade and currency exchanges. These directly exposed Russian firms to foreign competition. Mass privatization of small, medium and large state firms started in 1993. It was hoped that Russia's reforms and competitive pressures would compel free-market forces to improve efficiency and modernize workforce structures. Based on free-market economic theories, enterprises would be transformed from their social distribution functions to profit-making, competitive businesses. It was expected that unemployment would temporarily increase during this transition, as inefficient enterprises closed and successful ones excelled. In reality, these reforms combined with fluctuating monetary policy set off hyperinflation with steep declines in real wages and steady growth in unemployment until economic growth resumed after 1998 (Blasi et al 1997). Women were particularly hit by such hardships and institutional changes in terms of their rates of and quality of labor participation (Posadskay 1994, Standing 1994, Bridger and Kay 1996).

The law 'On employment of the population of the Russian Federation' (N 1032-1, April 19, 1991) was a reaction to these rapid changes that were taking place in labor relations. This law controls labor relations and state assistance to the

unemployed. From 1992 Goscomstat (State Committee on Statistics) started publishing systematized data on unemployment levels in Russia. There are two indicators: the level of registered unemployment and the level of total unemployment estimated from a sample survey of employment issues. The level of registered unemployment reflects the enrolment of unemployed people seeking a job in state employment service offices, but it does not reflect the actual size of the unemployed population in the country. The level of total unemployment is calculated according to International Labor Organization methodology and reflects unemployment more adequately. Figures 3.1 and 3.2 present the level of total unemployment among men and women from 1992-2004 based on data from Generation and Gender Programme.

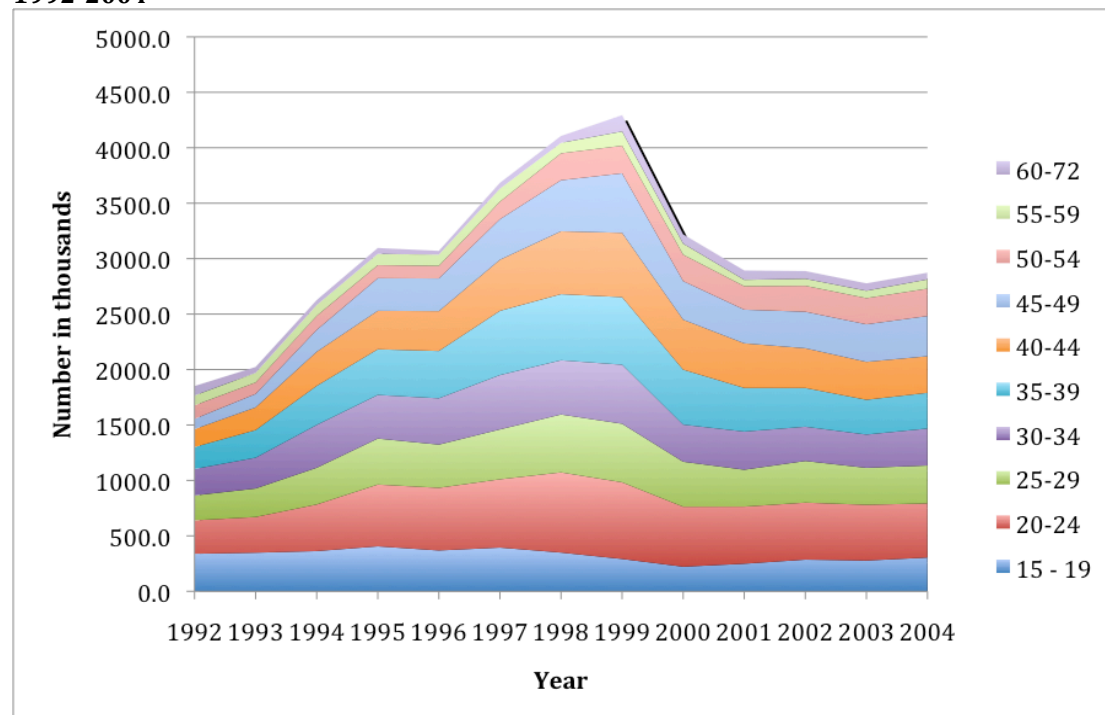
Figure 3.1 Level of unemployment by age for men, Generation and Gender Data, Russia 1992-2004



Figures 3.1 and 3.2 show that levels of unemployment were slightly higher among men than women during the early 1990s and during the peak of economic turmoil in the late 1990s. Since 1999 levels of unemployment have been decreasing and by 2004 levels of unemployment for men and women were almost identical among different age groups. It is important to not only consider levels of labor (non)participation but also the quality of jobs and wages. Using data from the Household and Labor Force Survey, the youth unemployment rate, aged 15-24, for women has increased from 16 percent in 1992 to 26 percent in 1999. The corresponding rate for men increased from 17 percent to 24 percent during the same period (UN Statistics Division 2008). Williamson and colleagues (2005) explain that, with the onset of market-capitalism, the country was unable to continue a wage structure based on wage standardization. Decreased industrial output, coupled with high inflation, produced a sharp decrease in both employment levels and real wages. This trend continued over most of the decade following the collapse of the Soviet Union, resulting in a situation where wages in 2000 were one-third of their 1990 levels (Zelenev, 2002). And it is evident that

women in particularly suffered the most in terms of quality and quantity of labor force participation.

Figure 3.2 Levels of unemployment by age for women, Generation and Gender Data, Russia 1992-2004



Parallel to these changes, since 1991, some demographers and educational specialists in Russia have been promoting theories of biological differentiation and calling for sex-specific upbringing for boys and girls. This new approach was seen to be necessary in order to prepare young people properly for adult roles which would now be presented as clearly structured along gender lines (Attwood 1995). Simultaneously, discussions in the Russian national media exaggerated and promoted the idea that the 'feminist' ideology formulated during the Soviet era had negative effects on marital relations and stable families (Kay 2002; Gerber and Mayorova 2006).

During the Soviet era, the official commitment to gender equality was based primarily on women's equal role in economic production alongside men, their equal rights to employment, education and political representation, and it remained unquestioned in the Soviet Union at least until the late 1980s. Yet problems arising in the practical implementation of this ideological commitment, coupled with concerns about a variety of possible demographic and social consequences, have produced fluctuations in policy regarding women and their roles, responsibilities and primary functions (Buckley 1997).

Kay (2002) observes that during this period of change, Russian women were encouraged to be exemplary wives, mothers and home-makers and to place renewed emphasis on their 'feminine' traits such as caring, softness, modesty and moral virtue. Such emphasis presented Russian women with ever-increasing

demands on their multiple roles in society. The dual demands of women in terms of their labor participation and domestic responsibilities had been always the case in Russia and most other countries (Remennic, 1999). However, since the collapse of the Russian Federation such emphasis on women's multiple roles became much more visible in the public sphere.

Some research on Russia (Ashwin and Bowers 1997, Monousova 1998, Reilly and Newell 2001) and other Eastern Europe states (Van der Lippe and Fodor 1998) suggests that market reforms may reduce gender inequality because women maintain their employment more effectively than men, despite having fewer opportunities in the most profitable areas of the economy. However, in an in-depth analysis of post-Soviet labor participation dynamics in relation to gender during 1991-1997, Gerber and Mayorova (2006) argue that gender differences change in a complex fashion. While women gained greater access to employment than men they were still disadvantaged in the quality of new jobs obtained and in their wages. By studying labor market transitions and job mobility, entry to or exit from employment, and the quality of the new jobs over time, they conclude that women are disadvantaged in the labor market in terms of having higher rates of layoff and voluntary employment exit, lower rates of employment entry and job mobility and higher odds that their new jobs are 'low-quality' positions with widening female disadvantages emerging in the quality of new jobs (Gerber and Mayorova 2006). Russian women tend to be found in low-grade technical and poorly paid professional occupations, such as healthcare, personal services and catering. During the market transition period wages stagnated in these types of jobs. Data from 1991-1995 show that Russian women were underrepresented in private sector firms, which usually pay higher wages than state-owned firms (Gerber and Hout 1998). Women's monthly earnings in 2000-02 were estimated to be 62 percent of those of men's, resulting in an effective long-term wage for women that was 69 percent smaller than men's (Oglobin 2005). Using published data extracted from the Generation and Gender Surveys and other statistical sources Table 3.1 presents labor participation rates for men and women from 1992 to 2003.

Table 3.1 Labor participation rates among different age groups by gender, Russia 1992-2003

Year	All working age of 15-72 years old			Working-age population (16 - 59 for men/ 16 – 54 for women)		
	Females	Males	All	Females	Males	All
1992	63.7	77.6	70.3	81.6	86.6	84.2
1993	61.3	75.6	68.1	79.4	84.7	82.2
1994	58.7	72.8	65.4	78.3	83.6	81.1
1995	58.3	72.1	64.8	77.6	82.8	80.3
1996	57.2	71.0	63.7	76.3	81.4	79.0
1997	55.9	69.4	62.3	74.5	79.8	77.2
1998	55.2	67.6	61.1	73.1	79.0	76.1
1999	59.7	71.9	65.5	76.0	81.7	79.0
2000	59.2	70.9	64.8	76.0	81.0	78.6
2001	58.8	70.3	64.3	74.1	80.2	77.2
2002	60.3	70.5	65.2	75.1	79.9	77.5
2003	60.6	70.9	65.5	74.6	80.0	77.3

Source: Federal State Statistics Service (Rosstat)

Examining labor participation rates among working age populations, as defined as 16-59 years for men and 16-54 for women, we can see that labor participation rates have declined for both men and women. However the gender gap has remained around 5 percent, and has been slightly increasing during the last few years. Considering a wider definition of working age as being 15-72 years, the data reveal that gender gaps in labor participation remain about 10 percent.

Moreover, Table 3.2 shows that relatively larger proportions of unemployed women are professional or skilled workers while the majority of unemployed men are those who usually work in unskilled jobs or hold no qualifications. For example, around 20 percent of unemployed women in 2004 have average or higher level of qualifications compared to only 9 percent among unemployed men. This highlights the potential unused female labor force in Russia and the need to find effective policies to facilitate and maintain women's labor participation in Russia.

Table 3.2 Distribution of unemployed people by gender and sector, Russia 2004

Sector	Women		Men	
	Number (Thousands)	%	Number (Thousands)	%
Government authorities leaders and all levels administration leaders, including heads of institutions, organizations, enterprises and their subdivisions	39	1.5	80	2.6
Professionals of high level qualification	203	7.7	130	4.2
Professionals of average level qualification	313	11.8	140	4.6
Employees occupied in compilation, execution of documentation, record maintenance and service	142	5.4	20	0.7
Workers occupied in service sector, housing maintenance and utility infrastructure, sales and related types of activity	550	20.7	175	5.7
Skilled workers occupied in agriculture, forestry, hunting, fish-farming and fisheries	81	3.1	85	2.8
Skilled workers occupied at small-scale and medium enterprises, art, crafts, construction, transport, communication, geology and exploration survey	208	7.8	657	21.4
Mechanics, processing machine operators, production system manipulators, assembly fitters	72	2.7	621	20.3
Unskilled workers	423	16.0	520	17.0
Persons having no profession and occupation	623	23.5	637	20.8
Total	2652		3064	

Source: Russian Statistical Annual, 2004

In section 2 we showed how the overall Russian population is projected to decline for both men and women while numbers and proportions of older age groups are projected to increase, resulting in higher dependency rates or needs for care and support. At the same time, labor participation rates during the previous cohort have been declining, particularly for women, and the literature shows that the quality and wage of women's labor participation are also of great concern. Concurrently, there is a growing emphasis on female dual roles

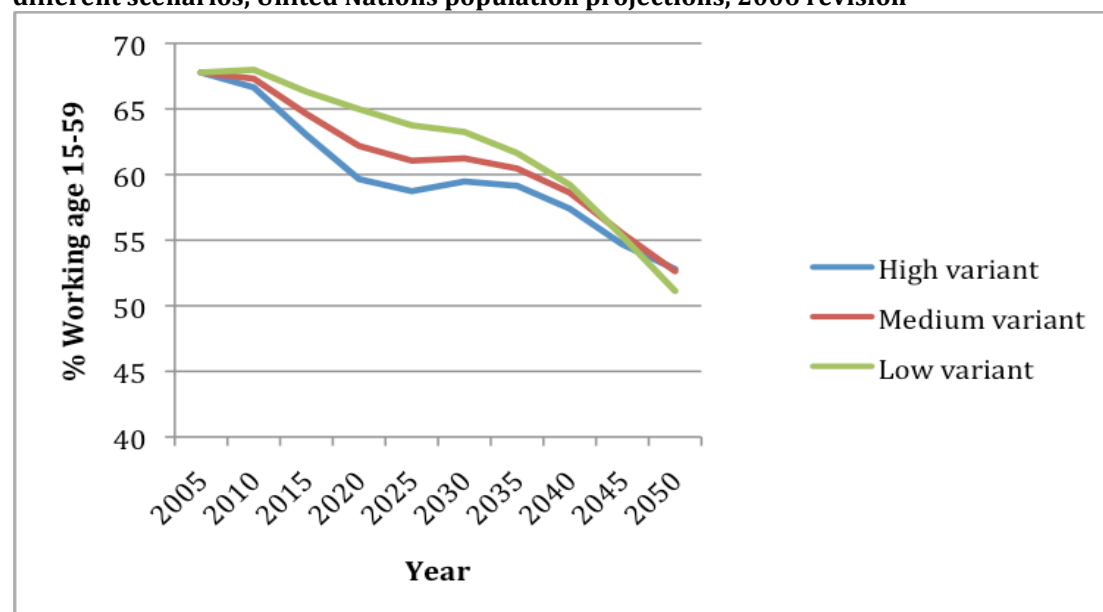
including providing long-term care for older people. All these factors have both direct and indirect effects on the size, productivity and wealth of the workforce.

One of the obvious consequences of population shrinkage, particularly among working age groups, is labor supply. For women, not only are available numbers directly related to such supply but so too are the expectations placed on them and their ability to balance their dual responsibilities. Government policies and social structures are directly linked to facilitating or hindering women's ability to participate fully in the labor market.

Working-age population projections

Based on the United Nations' population projections, the percentage of working age group 15-59 in Russia is projected to fall from around 68 percent in 2005 to 51 to 53 percent in 2050, depending on different fertility assumptions. Figure 3.3 clearly shows the loss in working age population as a proportion of total population in Russia even with high fertility variant, i.e. fertility is projected to be 0.5 children above the estimated medium projected fertility.

Figure 3.3 Projected working age groups in Russia from 2005 to 2050 based on three different scenarios, United Nations population projections, 2006 revision



Using different projection scenarios, Chawla and colleagues (World Bank 2007) project that Russia will lose from 5,406 to 8,966 thousand workers depending on different assumptions (see Table 3.3). The 'best' assumptions, resulting in the fewest losses, use projections of gradually increased labor participation rates for both men and women in the age group 40-59, resulting in rates that are 6 percent higher in 2020 than in 2005. The other two 'good' projections are based on an increase in older workers and a 2 percent across the board projection. The first assumes that labor participation rates among the 60-64 age group will gradually increase so that the rates are 10 percent higher in 2020 than in 2005. The later assumes a gradual increase in labor force participation rates for all age-

gender groups, reaching a level of two percentage points higher than they were in 2005. On the other hand, the assumptions that participation rates by age and gender will not change (Base case) and that they will move to the average of the 25 members of the European Union for all age groups (EU25 convergence), both result in the 'worst' projected participation rates for Russia. From all these different projections and scenarios it is apparent that Russia needs to make the most of its population, in terms of maximizing labor participation rates for both men and women and for those at different age groups, particularly 'older' workers. Moreover, even in the 'best' scenarios it is projected that Russia will lose more than 5 million of its labor force by 2020.

Table 3.3 Labor Force Projections for Russia under Different Scenarios, 2005-2020

Projection Scenario	2005 (thousands)	2020 (thousands)	Change (thousands)	2020 projection as percentage of total population in 2020
WAP 15-64 years old	101,599	90,847	-10,752	68.3
Base case projection	71,088 (49.6%)	63,759	-7,329	47.9
ILO projection	72,162	64,697	-7,465	48.6
EU25 convergence projection	71,088	62,122	-8,966	46.7
2% across the board projection	71,088	65,576	-5,512	49.3
40-59 year old increase projection	71,088	65,962	-5,126	49.6
Older workers increase projection	71,088	65,682	-5,406	49.3

Source: World Bank 2007

WAP= working age population

In Russia, the effects of aging population and shrinking working age population may have more overwhelming dimensions than in other developed countries, such as Japan and Western Europe. In Section 2, we showed that since the early 1990s long-term unemployment rates were on the increase, indicating a current level of relatively high unemployment in Russia. Also, families in Russia, as well as in other Eastern European countries, have fewer financial resources to alleviate the effects of aging and disabilities and the possibly negative consequences of labor market shortages (Chawla et al 2007).

On the other hand, current low labor participation rates in Russia, both among men and women, invite adequate policies to facilitate and improve labor participation in various sectors. Moreover, efforts need to be directed to facilitate both women's and older workers' (of both genders) participation in the labor market, and the promotion of improved working conditions and the reduction of possible discrimination in wages.

Migration can also play an important part in attracting much needed labor, as noted in Section 1 of this report, particularly from other neighboring Eastern European countries whose populations are not aging as rapidly as those of Russia. Between 1989 and 2002 Russia had a net gain of over 5.5 million migrants (Goskomstat, 2004), which made up for a significant fraction of the 7.5 million people lost through natural population decline. During the same period

an estimated 8 million people emigrated from Russia, usually people with high skills and education, however, the 13 million plus immigrants arriving in Russia tended to have relatively high levels of human capital. Although this migration was beneficial to Russia during the 1990s, some suggest that migration has tended to be less beneficial since 2000. However, the current political climate, including some racial intolerance of particular migrant groups such as ethnic Muslims or Chinese, makes it highly unlikely that large groups of potential migrants are willing to join or are welcomed in the Russian labor market (Donahue 2004).

4. The role of women in Long-Term Care provision in Russia

This section shows that the majority of long-term care is provided informally by women for their family members in Russia. Formal care provision is slowly increasing for older people; however, there are wide geographical variations. Women who are widows may be at particular risk of needing long-term care in later life. In Russia, as elsewhere, women provide the bulk of informal care and this is the case for employment in formal care. Financial and labor market policies for aging populations have been targeting women in the midlife age group to encourage higher labor market participation, such as by reversing trends towards early retirement. The capacity to do so is limited if women face caring responsibilities for their families for which they receive little support.

The provision of long-term care is one of the most important issues facing most developed countries and many less developed ones as well. As shown in the previous sections, changing demographic structures, labor market dynamics, migration policies and systems of financing long-term care all influence care provision. Informal care continues to play a major and central role in long-term care, and women remain predominant in the provision of both formal and informal care.

For Russian women, Remennick (1999) observes that under the Former Soviet Union, over 90 percent of Soviet women worked outside the home, usually full-time, while they simultaneously carried out most household, childcare and caring for older relatives tasks (Voronina 1994). These multiple roles continue to exist, and during the past 15 years more emphasis has been placed on women's roles and duties as care providers as well labor force participants (Teplova 2007). Russian traditional marriage patterns, with low median age at first marriage (early 20s) coupled with a relatively high divorce rate, with shortages of state housing for most households including the nuclear family and older relatives (Rimashevskaya, 1994) all influence the demand for care and the supply of care. Virtually all care for older people, when sick or disabled, takes place within families and is undertaken mostly by women (Barr and Field, 1996). Even when hospitalization is necessary, bedside or personal care such as help with eating and washing, is often provided by relatives rather than nursing staff; with the vast majority of hands-on care provided by daughters and daughters-in-law (Remennick, 1999).

During the past 15 years, the transformation of the Russian welfare state has led to the introduction of some formal care provision, albeit limited. Teplova (2007) uses Russian Longitudinal data to show that the role of women in Soviet society has changed over time, fluctuating with the broader political and economic goals of the state. For example, in the early socialist period, the Bolsheviks transformed the production base and society into a centrally administered industrial machine. The main objectives of welfare policies in that period were to support the mobilization of labor, in order to achieve ambitious industrial targets and to compete with the West. Women were predominantly seen as 'productive units' (Derluguian and Greer 2000).

From the 1930s, women and men were caught up in the turmoil of life under Stalin's rule. Shortages of food, housing, and other goods led to cutbacks in programs designed to ease the double burden of women's labor. Many kindergartens and nurseries were closed. A new Soviet woman was needed who would 'have equal rights with men in all spheres of economic, state, cultural, social and political life' (Constitution of the USSR 1938), but who would be a loving wife and mother. Clements, Engel, and Worobec (1991) argue that there were fundamental purposes behind the promotion of the image of this new Soviet woman. Her unpaid household labor freed resources for industrialization. This period led to the emergence of two ideologies with regard to the status of women in society: 'an ideology of equality which existed in laws and statutes, and a patriarchal ideology which operated in real life' (Khotkina 2001).

Russian social policies regarding female labor participation have indeed increased women's participation in the formal workforce, accompanied by the growth in female-headed households, yet changes in traditional gender-role attitudes are only slowly emerging (Motiejunaite and Kravchenko 2008). These authors conclude that this is mainly attributable to the difference between the 'official' and 'everyday' gender contracts. As defined by Gottfried (2000), a gender contract is a 'compromise made about the gender division of labor, at work, and by implication, at home'. Thus the 'official' contract is shaped and influenced by public policies and legislation, while the 'everyday' contract is sustained through individuals' cultural, routine behavior and attitudes, informally and through subtle knowledge.

Formal Care

Prior to 1995 there were no laws in Russia regarding care of older people and thus there was virtually no formal care provision. From 1995 two laws were introduced to set up organized care for older people. The first Federal Law took effect from August 1995 (No. 122-FZ) 'On Social Service for Elderly and Disabled Citizens' and the second Federal Law from December 1995 (No. 195-FZ) 'On Social Service Principles in the Russian Federation'. However, many researchers argue that since the collapse of the Soviet Union, older people have become even more impoverished and are more often left with no formal social support and more reliant on informal support, mostly carried out by women (Heleniak, 2004; Jensen & Richter, 2004; Tchernina & Tchernin, 2002).

The social services organizations established were managed by executive authorities of the Russian Federation constituent entities, that is, managed regionally and not centrally, and funded from the budgets of the Russian Federation constituent entities. Social service activities can be carried out by governmental and non-governmental social services organizations, including individuals providing private social services. Such decentralization in care provision has been disadvantaged by lack of institutional capacity (Danishevski et al 2005). The right to a social service is granted to older citizens, that is, men over 60, women over 55, and disabled people who need other people's permanent or temporary assistance due to their partial or complete loss of

ability to carry on main everyday needs on their own as a result of limited ability to care for themselves and/or to move. The decision to provide social services is made by local social security authorities. The forms of social services provided to older and disabled citizens are as follows:

- 1) social services at home (including social and medical care);
- 2) semi-institutional social services during the day (and/or night) at care facilities of social services institutions;
- 3) residential social service institutions (boarding houses, rest homes and other social service institutions, irrespective of their name);
- 4) emergency social services;
- 5) social consultation services.

(Source: Generation and Gender Program)

The provisions of these services are highly dependant on the resources available to each constituent entity and thus wide geographical variations in social care provision occur, similar to general health care provision (Chernichovsky and Potapchik 1999; Danishevski 2005). It is evident from the literature that the majority of long-term care is provided informally in Russia, however, formal care provision has increased, although not dramatically, from 1998 to 2003. According to the Russian Statistical Annual, the number of older citizens who attend social services centers either for short breaks or on a daily basis increased from 529,000 in 1998 to 861,000 in 2003. Similarly, the number of those provided with care at home increased from 1,030,000 to 1,122,000 during the same period of time (Table 4.1). Table 4.2 also shows an increase in both residential long-term care institutions as well as the number of people using such services. The data show a small growth in the number of residents (around 12,000) from 1990 to 2003.

It is also important to remember the vast geographical size of Russia and that significant regional variations exist. A study by Struyk et al (2004) examining levels of satisfaction of older people using home care services in rural Russia highlighted the extremely difficult circumstances lived in by some rural older people. Most of the sampled population did not have running water or toilets inside their houses. This study also draw attention to the fact that many older people in Russia are living alone and while nearly two-thirds had regular informal care in addition to state support, a high proportion (26%) of their sample did not receive any informal care, mainly due to the unavailability of relatives or other supporters.

Table 4.3 shows the trends in the number of men and women working in the social care sector from 1997 and 2003 in Russia. As the data shows, women are more represented in this sector, as is the case in many other countries. This was particularly evident in 'health care and social services' sector. It is no surprise to observe the over representation of women providing formal care, evidence from other developed countries show similar patterns (Eborall and Griffiths 2008; OECD 2005).

Table 4.1 Number (in thousands) of older people receiving different formal day care provided by social services in Russia from 1998 to 2003

Year	Number of elderly and disabled people attending departments of social services centres	Number of elderly and disabled people attending social service day centres	Elderly and disabled people receiving support at home	Number of single older and disabled people receiving support from departments of urgent social services,
1998	44	485	1030	..
1999	45	594	1049	10344
2000	41	707	1067	..
2001	55	825	1104	..
2002	52	809	1103	..
2003	58	803	1122	..

Source: Russian Statistical Annual. 2001: Stat. annual/ Goskomstat RF. – M., 2001. Social situation and Life Standard in Russia: Stat annual / Goskomstat RF. – M., 1997. Social situation and Life Standard in Russia: Stat annual/ Rosstat. – M., 2004; Pension fund scheme and social security of population in Russian Federation in 1999 : Stat annual. / RF Ministry of Labor. – M, 2000.

Notes: numbers in thousands; impossible to distinguish elderly people and disabled; no data about number of men and women separately; data for 1998-2003 years has a divergence according to three different sources; data from Social Situation and Life Standard in Russia are cited here.

Table 4.2 Number of residential facilities for older people or those with disabilities in Russia and number of people using such services in thousands from 1990 to 2003

Year	Number of residential facilities for elderly and disabled people (adults)	Number of elderly and disabled people living in residential facilities (adults), - thousand people
1990	726	213
1991	737	207
1992	742	200
1993	788	197
1994	848	199
1995	871	202
1996	904	204
1997	926	202
1998	1002	211
1999	1031	206
2000	1132	212
2001	1159	217
2002	1207	219
2003	1248	224

Source: Russian Statistical Annual. 2001: Stat. annual/ Goskomstat RF. - M., 2001. p. 255. Social situation and Life Standard in Russia: Stat annual / Goskomstat RF. - M., 1997. p. 211. Social situation and Life Standard in Russia: Stat annual/ Rosstat. - M., 2004. p. 251-252. Pension fund scheme and social security of population in Russian Federation in 1999: Stat annual. / RF Ministry of Labor. - M, 2000. p. 81.

Notes: impossible to distinguish elderly people and disabled; no data about number of men and women separately; data for 1998-2003 years has a divergence according to three different sources; data from Social Situation and Life Standard in Russia are cited here.

Table 4.3 Number of men and women working in sectors related to long-term care provision in Russia from 1997 to 2003 in thousands

Gender and year	Health care and social services	Other communal, social and personal services	Household services	Total
Men				
1997	760	2434		3194
1998	767	2404		3171
1999	778	2411		3189
2000	784	2579	1	3364
2001	885	2200	3	3088
2002	872	2188	1	3061
2003	875	717	6	1598
Women				
1997	3416	2100		5516
1998	3368	2064		5432
1999	3555	2173		5728
2000	3706	2392	3	6101
2001	3764	1958	11	5733
2002	3818	2082	11	5911
2003	3915	1350	10	5275

Source: ILO. Laborsta

Informal care

Demographic, economic, and social factors have obvious and large effects on informal caregivers' availability (Miller and Weissert 2000, Hussein and Manthorpe 2005). For instance, if female longevity increases more rapidly than male longevity, women can expect to spend more years in widowhood, without the support of a spouse, leading to greater risks of needing formal long-term care (Lakdawalla and Philipson 1999). Women's participation in the labor workforce also reduces their availability to provide informal care for parents, parents-in-law and grandparents, therefore the limited availability of potential providers of informal care is directly associated with increased demand for formal long-term care (Coughlin et al 1990, Miller and Weissert 2000, Yoo et al 2004).

In most of the developed world, women provide the bulk of informal care, although with marked differences across countries (Table 4.4). In some countries, men are more likely to take over the role of carer or caregiver for their spouses than men in other family roles. However, this is unlikely to be the case in Russia where increasing numbers of older people are living alone, particularly women. However, in other developed countries where more older people are living as couples and for a longer time, this has led to increases in the participation of men in informal care giving over time (Sundström et al., 2006). There are, however, gender differences in the levels of care provided, which are not shown in the data. Women predominate among informal carers with the heaviest commitments. They are more likely to be the main carer rather than an additional carer. The greater the need for personal care services, the more likely it is that women provide them. On the other hand, the share of domestic help rather than personal care is correspondingly higher for male carers (OECD 2005).

Table 4.4 Relationship between care recipient and informal carers in different countries

Country (source)	Year	Relationship	Total	Male	Female
Australia (ABS survey if disability, aging and carers, 1998)	1998	Partner	43	19	24
		Parent	22	3	19
		Child	24	6	19
		Other	11	2	9
		Total	100	30	71
Austria (Microcensus 2002)	2002	Partner	18	7	11
		Child	38	14	24
		Other	43	12	32
		Total	100	34	66
Canada (Survey on informal caregivers to adults in British Columbia)	1995	Partner	20	7	13
		Child	35	9	26
		Others	45	11	34
		Total	100	27	73
Germany (Schneekloth and Muller, 2000)	1998	Partner	32	12	20
		Parent	13	2	11
		Child	28	5	23
		Other	27	1	26
		Total	100	20	80
Ireland (Survey of older persons, 1993)	1993	Partner	22	5	17
		Parent			
		Child	48	13	35
		Other			
Japan (Comprehensive survey of living conditions, 2001)	2001	Total			
		Partner	36	12	25
		Parent	1	0	1
		Child	60	11	48
		Other	3	1	3
South Korea (Survey on long-term care needs of the elderly, 2001)	2001	Total	100	24	76
		Partner	32		
		Child	55	7	49
		Other	13		
Spain (Survey on impairment, disabilities and handicaps)	1999	Total	100		
		Partner	23		
		Child	38	6	32
		Other	39		
Sweden (Survey of aged care, 2000)	2000	Total	100		
		Child	46	13	33
		Other	53		
UK (General household survey, 2000)	2000	Total	100		
		Partner	15		
		Parent	7		
		Child	43		
		Other	35		
US (National long term care survey, 1994)	1994	Total1	100		
		Partner	23	10	13
		Child	41	15	27
		Other2	35	11	24
		Total	100	36	64

Table reproduced from OECD 2005

Note: Definition of carers and care recipients may differ between countries. The number of informal carers is usually higher than the number of carers receiving support under public long-term care programs (e.g. as cash allowances).

1. National data on the shares of care-recipients in the different categories, which include persons receiving care from more than one carer, have been recalculated to add up to 100. 2. Missing values are included in the category "Other".

In relation to the age of informal carers, across countries there seems to be a peak in care giving by those aged 45-65 (Table 4.5). This is the age group that frequently has multiple care responsibilities for parents or for a spouse or

partner with age-related health problems. In addition, fiscal and labor market policies for aging populations have been targeting this age group to encourage higher labor market participation, such as by reversing trends towards early retirement. It will be important to ensure that caring responsibilities can be combined with employment in this age group. Although concerns have been expressed about declining care potential from children, in at least one of the countries in this study, the United Kingdom, research has shown that the proportion of older people with at least one surviving child will be exceptionally high for the cohort reaching late old age over the next two decades (Comas-Herrera and Wittenberg, 2003). This suggests that, other factors remaining equal, the supply of informal care by children relative to demand is likely, at least, to be sustained over the coming two decades.

Table 4.3 Age distribution of informal carers in different OECD countries

Year	Year	44 and less	45-64	65 and over
Australia	1998	47	36	17
Austria	2002	27	48	25
Canada ¹	1995	35	42	23
Germany ²	1998	15	53	33
Ireland	2002	46	43	11
Japan ³	2001	4	42	54
South Korea	2001	30	39	31
UK ⁴	2000	35	45	20
US ⁵	1994	12	37	51

1. British Columbia only. 2. Germany: main carer only, age groups refer to -39, 40-64, 65+. 3. Japan: age groups refer to -30, 40-59, 60+. 4. United Kingdom: age groups refer to 16-44, 45-64, 65+. 5. Primary active caregivers only.
Source: OECD 2005.

In Russia the available data indicate that the use of formal care by older people is not substantial but that it is growing in extent. Women are over-represented in formal care provision as employees, as in other countries. In relation to informal long-term care, which is the most common form of care provision, the literature also stresses the sizeable role women play. Most long-term care in Russia, as in the majority of Eastern Europe, is provided informally or, for people with severe health conditions, in hospital settings (Chawla et al, 2007), and the majority of such informal care is provided by women (Barr and Field, 1996; Remennick, 1999).

5. Review of global evidence and estimates of long-term care costs

This section considers experiences in other countries that are also facing the challenges of aging populations and need for long-term care from informal carers and formal services. One key point is that highest health expenditures are significantly associated with the few years or months prior to death rather than the older population as a whole. Public policy in many developed countries has shifted resources to support home-care services rather than developing institutional care. To support this many countries provide a range of financial incentives or compensations for family members providing care. These are illustrated in this section.

There are widespread concerns that rapidly aging populations in many countries in Eastern Europe and the Russian Federation will have significantly higher health care requirements than previous generations. Long-term care will become more costly as the availability of informal, family-based, care declines, and similarly it may present large opportunity costs if younger working-age people spend their time providing care instead of participating in the labor force or their productivity is affected. The magnitude of such implications depends crucially on healthy life expectancy rather than just life expectancy, that is whether longevity brings more healthy years or adds more years of illness and dependency.

A large number of studies, primarily concentrated on countries of Western Europe and in Japan, document the impact of aging on health and health expenditures and confirm the high level of use of health services in old age, particularly ambulatory services, medication, hospital admissions, and surgery. The general finding in most assessments is that health expenditure per episode is typically higher for older people, though use levels off and even declines for the very old. Large variations exist across countries: aging predicts health care expenditures better in Japan than in Australia, Canada, or the United Kingdom. Yet many studies also show that aging is not a significant factor affecting health expenditures if proximity to death is taken into account, because a large proportion of lifetime expenditures on health takes place in the two years preceding death, irrespective of the individual's age at that time. Expenditure levels therefore depend not only on life expectancy but also on number of years lived in ill health, or with mental or physical disability. Thus, highest health expenditures are significantly associated with the few years or months directly prior to death, regardless of age at death, i.e. proximity to death. For example, McGail and colleagues (2000) conclude that age is less important than proximity to death as a predictor of 'health' costs, although such effect is not as important in relation to social and nursing care costs.

Economic and social policies have been found to be particularly important determinants of health expenditures, more than direct demographic factors such as aging (Castles 2000; Richardson and Robertson 1999; World Bank 2007). From the same research of Castles (2000), governing party preferences were significantly associated with level of expenditures in long-term care.

Employment policies also have notable effects on level of expenditure through direct and indirect role in terms of the availability and cost of informal care (Yoo et al 2004, Comas-Herrera and Wittenberg 2003), also in terms of how employment policies are adapted for older age (Taylor 2003). Directly linked are the overall wage levels in a country which play important effects on the cost of long-term care services (Comas-Herrera and Wittenberg 2003).

The Survey of Health, Ageing, and Retirement in Europe (SHARE) study provides substantial evidence, based on 20,000 continental Europeans older than 50, that the levels and rates of use of health services fall among the 'oldest old', those older than 85, while the peak occurs among those aged 75-79. Such analysis suggests that the rapid increase in the numbers of the 'very old' may not be as great cause of concern as anticipated, however, it is directly linked with the increases in numbers of the 'young old' (65-79) which will require greater resources to meet their health needs (Börsch-Supan et al 2005).

Chawla et al (2007), using three different scenarios, estimate that health expenditure in Russia will change from 3.16 percent of GDP in 2005 to range from 3.15 to 3.38 percent of GDP in 2050. The lowest level of estimated change is observed under a Compressed Morbidity Scenario, which is the most optimistic one and assumes that morbidity levels in additional years of life in future years are lower than at present, meaning that all additional life years are lived more healthily. The greatest estimated changes are observed under a Pure Aging Scenario, which assumes that the number of years spent in good health remains constant and that all additional years of life are assumed to be spent in ill health.

It is much more complex to project public expenditure for long-term care as it incorporates a wide mix of social, medical and residential aspects, including both health, social and nursing care costs. Long-term care spending is determined by a number of independent but interacting factors, such as changing demographics, economic, political and social policies as well as economic growth and technological innovations. A broad mix of professional, volunteers and non-professionals, such as friends and families, can provide care and support, particularly home care. However, sheltered housing and old-age homes are usually operated and paid for by public funds in the East European region, including Russia (World Bank 2007). More recently, voluntary and nongovernmental organizations are playing an increasing role in the provision of hospices, rehabilitation services and nursing homes, as well as long-term care services in the community (OECD 2005).

Governments' role and spending on long-term care (LTC)

In a review of governments' spending on long-term care among OECD countries; Austria, Germany, Japan and Luxembourg are among the countries which have in place **comprehensive public programs** for LTC funded through social insurance programs, while other countries, such as the Nordic states, provide comprehensive services that are tax-funded while in Australia and the UK, most programs are means-tested. Financing of LTC services is drawn from different sources in different countries. In many developed countries, taxation is the main

source of public financing. Norway and Sweden, for example, offer universal coverage of LTC services from general taxation, but differ in the cost sharing required for services provided in nursing homes. Austria also has a universal LTC system funded from general taxation.

Another financing route is through universal ***social insurance schemes*** specifically to cover LTC such as the case in Germany, Japan, the Netherlands and Luxembourg. In other countries such as Hungary, South Korea, Mexico and Poland, the main health insurance programs finance only a limited amount of care in hospitals and the total involved is quite small (OECD 2005).

In addition to countries that opt for universal access provision, there are a few that have largely ***means-tested systems*** in which the users of LTC or their families are expected to bear all or most of the costs, depending on their level of income. For example, in Australia, the provision of institutional and home care, both of which are funded through general taxation, is means-tested where users are charged according to their ability to pay. Similar means-tested provisions are in place in Canada, Ireland, New Zealand, and the United Kingdom. In other European countries, such as Greece, Spain and Italy, there is continuing reliance on ***traditional provision of informal care*** (Diaz et al, 2002; Lamura et al 2003); and the small amount of formal care provided in Spain, for example, is means-tested and funded through general taxation (OECD 2005).

New forms of public programs for LTC are emerging. For example, in Austria, a ***tax-funded system of LTC allowances*** was introduced in 1993, payable in cash only, and the amounts are determined by a seven-point scale. The allowance replaced a pre-existing number of allowances for different groups. One of the main objectives of this reform was to address the inequities generated by the previous different allowances. While the new allowances are funded from general taxation, the level of contributions to health insurance was increased by 0.8 percent for the self-employed and farmers, and by 0.5 percent for retired people.

In Germany, a ***public scheme of LTC insurance*** was introduced in 1995-96, which comprises a mandatory public scheme and a private insurance scheme. The public scheme is administered by the health insurance funds while the private scheme is administered by private insurers according to federal regulations, where the private scheme must provide at least the same benefits as the public scheme.

How governments support women providing informal long-term care

Examining 19 OECD countries, total expenditure on LTC ranges from below 0.2 to around 3 percent of GDP. Most countries are clustered in range between 0.5 percent and 1.6 percent of GDP. Only Norway and Sweden have expenditure ratios well above this level at 2.15 and 3 percent respectively. Overall, public spending on LTC is still relatively low as a proportion of GDP, when compared with other aging-related expenditure, such as pensions or acute health care. Spending on institutional care accounts for over half of public spending on LTC

in OECD countries but home care programs are increasingly becoming a preferred option for most people receiving LTC. In addition, the majority of home care recipients receive additional informal care from family or friends supporting them by providing additional services, the majority of which are unpaid. Public policy has consequently, over time, shifted a larger share of resources to support home-care services in a number of ways. These range from encouraging a large supply of home-care providers in the community, more support services, such as counseling and respite, and launching programs of consumer choice in various forms such as 'cash for care' payments or personal budgets.

The **United Kingdom** provides a cash benefit known as Carer's Allowance to provide support to carers. To be eligible, carers must have limited income or savings and be providing a minimum of 35 hours of care a week to a person who is themselves in receipt of a benefit awarded to pay for care and attention (Attendance Allowance or Disability Living Allowance). Until 2002, Carer's Allowance was available only to carers aged below 65, but eligibility was then extended to those over this age, subject to a means test.

In **Germany**, informal care continues to play its traditional strong role, and this is reflected in the benefit system allowing a recipient to draw a cash allowance, which can be used to pay informal carers or careworkers. Non-profit organizations are the major providers of long-term care services at home. The introduction of long-term care insurance has resulted in the strong growth of providers of home-care services, which by law have to be mainly private providers (either non-for-profit or for-profit). This is based on the view that a system of private providers will create an environment of competition, leading to better outcomes in terms of cost and quality of care than a system dominated by public sector providers.

In **Ireland**, the Carer's Allowance is a payment for carers with low income who live with and look after people who need full-time care and attention. Carer's Benefit is a payment made to insured persons who leave the workforce temporarily to care for a person in need of full-time care and attention. In order to receive these benefits, the care recipient must be so disabled as to require full-time care and attention but not normally living in a hospital, care home or other institution.

In **Norway**, the government plays the dominant role in long-term care, as the public sector provides most services and these are largely financed by direct taxation. However, provision of long-term care services is largely decentralized and integrated at the level of the municipality. In 1988, Norway introduced payments for informal care under the Municipal Health Services Act of 1986. People caring for older relatives or disabled children on a regular basis may receive a cash benefit from the municipality called 'caregiver pay'. In **Sweden**, there are primarily three types of support: respite and relief services, support and educational groups for carers and economic support for caring. Informal carers can be supported through a Home Care Allowance, respite care for the older person in day-care centers or short-term stays for the older person in care

homes. A number of cash benefits are available for informal carers, and a carer can be directly employed by the municipality to care for an older person. This system is mostly used when the caregiver is of working age and in sparsely populated areas. Paid care leave is available if a person cares for a relative or family member who is terminally ill.

Luxembourg has a social insurance system covering old age and acute health care, and in 1998 introduced a new arm of social insurance to cover long-term care. Since 2001, the share of disabled older people who are cared for at home has been steadily increasing, from 53 percent of all long-term care beneficiaries in 2001 to 60.4 percent in 2004, and the size of home-care workforce has consequently increased by 21 percent from 1999 to 2002. There is no evidence of programs aimed at supporting informal carers, including women, in Luxembourg. Poland provides tax relief on expenses involved in the care of a dependent relative. Polish workers can also take time off work with compensation, up to 14 days per year.

On the other hand, there are no national programs aimed at providing support and service for informal caregivers in **Austria**. Social services for older people and the disabled have a relatively well-developed institutional network in **Hungary**. However, they do not meet growing needs either in terms of number of places or quality of the services. Similar to Austria there are no established programs to support informal carers in Hungary.

Outside Europe, in the **United States**, as with other OECD countries, informal care from families and others considerably exceeds the extent of formal care services. An estimated one in four households is providing help to someone aged 50 or over with care needs. In **Canada**, where about 80 percent of older people's care is provided by family and friends (OECD 2005), Health Canada contributed to the creation of the 'Canadian Caregiver Coalition' in 2000. The aim of this coalition was to drive forward research and policy development on issues such as the role of the family carer in the home care sector, the role of men as carers, out-of-pocket expenses, respite care and employment implications. Canada introduced a new cash benefit for informal carers in 2004. This includes provision for a new Employment Insurance (EI) benefit called the Compassionate Care Benefit (CCB). From January 2004, CCB is available for EI workers who take leave from work due to caring responsibilities for a close relative (child, parent or spouse) who has a serious medical condition that places him/her at high risk of death within six months. In Canada, federal, provincial and territorial governments also provide indirect financial assistance to carers via tax relief. The federal Caregiver Tax Credit is a non-refundable tax credit designed to reduce the income tax owed by individuals who reside with and provide home care to disabled relative(s).

Turning to Asia, **South Korea** does not currently have a comprehensive long-term care system. The great majority of older people who need help with activities of daily living are currently cared for informally in families, with only a small number of people receiving formal long-term care services. As in the case

of **Austria** and **Hungary**, there are no established programs aimed at supporting informal carers in South Korea. Allowances for families caring for older relatives are available in **Japan** and are funded by the municipalities with a subsidy from central government. The amounts of benefit, eligibility criteria, as well as the availability of the whole scheme, are determined by each municipality. Those who are eligible are usually families caring for older people with the most severe needs. It is reported that very small number of families are in receipt of this allowance.

Lastly, in **Australia**, the government funds a number of services aimed to recognize the contribution made by informal carers, with the Carer Payment as one of these main services. Although the Carer Payment is an income-support payment, it aims to compensate carers for being unable to undertake substantial work. A Carer Allowance is also available, which is an income supplement for people who provide daily care at home for an adult or child with a disability or severe medical condition. The National Respite for Carers Program provides funding for short term or emergency respite in the community. One of the remits of the program is to provide carers with information, advice and counseling as well as assistance to take a break from caring. In addition, there is 'residential respite' providing short-term stay-in care homes for people who are in temporary need of a break.

This review illustrates some of the complexities of the design of different informal care support systems in different countries, such systems are part of a wider long-term care policies which are discussed in more details in the World Health Organization report on long-term care (WHO, 2003).

6. How do women balance their dual role as participants in the labor market and also as informal carers?

This section outlines the ways in which women in Russia and elsewhere juggle work and caring. Policies enabling more flexible working hours and provision of paid leave emerge as particularly important for women seeking to manage both roles. Informal support for women to share their caring responsibilities with partners, older children, friends or other members of the community may assist women to retain their roles in the labor force.

As we discussed earlier the facet of political and economic development in Russia is underpinned by the idea of gender equality in relation to the provision of educational and work opportunities and the use of public measures aimed at reconciling work and parenting responsibilities. However, the system has historically lacked recognition of the value of family care, which lies outside the public sphere. This undermines the multiple responsibilities and roles faced by women, particularly in Russian society where domestic and caring responsibilities are considered to be a natural role for women (Barr and Field 1996; Motiejunaite and Kravchenko 2008). In a study examining the relationships between LTC expenditure and the availability of informal carers in 15 OECD countries, Yoo and colleagues (2004) identify the availability of an informal carer, particularly a spouse, as one of the most important factors explaining variations in LTC expenditure growth.

Women, are the majority of informal carers of older people and children. Since the early 1980s, middle aged women have often been referred to as the 'sandwich generation'; due to commonly experienced dual care responsibilities for older parents/parents in law and children as well as participation in the labor market (Miller, 1989; Rosenthal, 1997; Remennick, 1999). It is obvious that women who care for both their parents and children while participating in the labor market may experience special role strain. The ability to balance responsibilities relates to both the extent and quality of services available in the country and region where women live, as well as women's own personal characteristics, such as financial resources and educational levels, and the wider community context influencing the availability of an extended family, friends and social networks. As discussed in Section 5, the resources available to informal carers vary dramatically in different countries. Moreover, women from disadvantaged groups, such as those with very low educational level, immigrants or single mothers, may face added pressures. Nonetheless, the literature on caregivers' stress highlights several positive and negative aspects, noting that while multiple roles may involve emotional distress arising from often-conflicting demands of care and work, caring for older people and children is also rewarding. However, women whose paid jobs also involve formal care (such as nurses and care workers) may experience heightened emotional demands (Arber, 1991; Krous and Afifi, 2007). Many studies report that women usually pay a high price for such multiple roles in terms of their psychological and mental health, including depression (Schulz et al 1995, Doress-Worters, 1994).

Some studies of employees who provide long-term care to parents or other relatives have shown that the demands of caring responsibilities and employment usually interfere with each other (Gignac et al 1996; Scharlach, 1994, Stephens et al 2001). Usually bi-directional stress and interference are observed, where not only employment interferes with caring responsibilities but *vice versa* (Stephens and Townsend 1997). On the other hand, the 'expansion theory' argues that multiple roles can enhance an individual's energy and health. This assumption is based on the principle that different roles provide different resources to the individual (Marks, 1977). In general, there is wide research suggesting that employed women, regardless of their caring responsibilities, tend to have better health indicators, such as less psychological stress, better physical health and higher self-esteem (Aneshensel et al 1995; Bromberger and Matthews, 1994, Ross and Mirowsky 1995). Moreover, research on providing care in later life has shown the direct benefits of employment for informal carers (Brody et al 1987, Skaff and Pearlin 1992, Stephens et al 2001). Time spent at work has the potential to provide women with some form of respite or distraction from usual caring responsibilities. Furthermore, employment increases women's income as well as their social and psychological resources. However, most of the literature focuses on informal carers who are employed in professional roles and there is less known about the effect of multiple roles on women who are employed in less skilled occupations. To sum up, the effect of multiple roles on women's health and wellbeing is governed by two theoretical perspectives: 'role strain' and 'role enhancement' theories. Traditionally these have been regarded as opposing perspectives but more recent research is showing that they are more likely to be complementary theories (Stephens and Franks 1999; Martire and Stephens 2003).

Recent research suggests that it is beneficial for employers to support their staff with their caring responsibilities (Yeandle et al 2006) and different support models are used by employers in different countries (see Section 7 for examples). Flexible and supportive work environments are essential in enabling people who provide informal care to also participate in the labor market (Phillips et al 2002; Seddon et al 2004). It is also evident that competing multiple demands may cause carers to cease work completely, due to their caring responsibilities (Arber and Ginn 1995), but the literature suggests that the majority of carers manage, or are forced to manage, a combination of the two activities (Glendinning 1992, Joshi 1995).

In the context of Russia, Teplova (2005) explores the increasing difficulties faced by Russian women when balancing their caring and formal employment responsibilities. She observes that although female labor participation was historically high in the Soviet period, the position of women has deteriorated dramatically in the post-Soviet era. This deteriorating position is observed both in the quantities as well as the qualities of employment among women. Teplova emphasizes that, in addition to political and economic drivers, such as privatization, the role of family policies is crucial in explaining such changes. Family support systems in Russia at the onset of transformation were widely available and tended to be generous and comprehensive specifically in relation

to childcare. Most family programs were designed by central government but delivered through state enterprises, agricultural collectives, and local government.

During the Soviet period, several programs, including childcare and leave provisions, were attached to the workplace; however, they rarely addressed how to support employers who provide care for older relatives. Such family policies supported women's participation in the labor force, but also made employment the main access route to childcare and related services. The last 15 years or so have seen fundamental changes in childcare arrangements, job protection for (pregnant) women, and maternity/parental leave policies in Russia. Familial policies have been introduced to encourage women to have children and stay at home with them. There has been a movement from Soviet-style enterprise level provision of services to a more Western European, social insurance model, where the government collects social insurance or social security premiums and pays out maternity or parental or other benefits.

Remennick (1999) discusses how Russian women migrants in Israel manage their multiple roles as carers and workers in a new society. Remennick explains that family formation and caring responsibilities among Soviet Jews are highly similar to those observed among the rest of the Russian population, with low age at first marriage, and that caring responsibilities, for children or older people, are regarded as a natural female responsibility. Inter-generational ties in the Jewish families in this study were perceived to be even stronger than in the rest of the Russian population. Over 700,000 Soviet Jews migrants arrived in Israel mainly during 1990-92, most were mass family resettlement with two or three generations as a family chain. From interviews with 30 women in 1997, Remennick observes that most women were caring for older relatives, children *and* working outside the home, which caused high levels of emotional strain on women. The study found that coping patterns and role management styles varied by women's age, social background, employment type and family structure. One of the main coping strategies was sharing care responsibilities with another family member, such as a partner or an older child. Those with better employment situations resorted to other forms of 'care share' by employing workers who provided care to older people. Remennick concludes that women holding the lowest paid jobs faced the greatest challenges in meeting their multiple roles, which added significant physical and mental stress to their lives.

Data from the 2001 United Kingdom census shows that the majority of working carers in England and Wales are less likely to hold university degrees and are concentrated in lower-level jobs (Buckner and Yeandle 2006). Whether people with lower qualifications and jobs were more available to provide informal care or because of caring responsibilities they lost or gave up education and employment opportunities is questionable (Lundsgaard 2005; Himmelweit and Land 2008). In the UK, Arksey and Glendinning (2008) explore carers' decision-making process around work and care in interviews with 80 working-age carers. They again conclude that decision-making processes, relating to labor force participation and managing strategies, depend on different characteristics such as age, gender, ethnicity and levels of need among people being care for. In many

cases, carers were forced to cease employment due to pragmatic or practical reasons and against their wishes. Arksey and Glendinning observe the added challenges of different geographical locations, for example, it takes less time to travel to work in urban than rural locations, which adds another barrier to rural residents if they wish to participate in the labor market. Moreover, fewer job opportunities are available in rural than urban locations. One of their main conclusions was the importance of the availability of flexible working hours which were critical in enabling carers to combine work and caregiving. Self-employment was perceived to be a suitable option in theory; however, it was unrealistic if it requires traveling or being available at certain times during the day.

Also in the United Kingdom, using data from the General Household Survey (GHS), Evandrou and Glaser (2004) compare caring responsibilities for different birth cohorts from 1923-30 to 1941-95. They show that traditionally in the United Kingdom it was rare for women to simultaneously combine family, care and work responsibilities. Only one-in-nine women aged 45-59 years born during 1941-45 occupied all three roles at the same time. However, the prevalence of multiple roles is increasing among younger cohorts, particularly the combination of caring and paid work. Their analysis indicates a significant increase in the likelihood of providing intensive care to an older or disabled relative during mid-life (45-59 years).

In the United States, Pavalko and Henderson (2006) found that women who provide care are more likely to cease work if their employment conditions are not supportive. On the other hand, women employed in jobs that have access to flexible hours, paid and unpaid family leave, and paid sick leave are more likely to remain employed and maintain most of their working hours. Using data from the National Longitudinal Survey of Young Women, 1995 to 2001, Pavalko and Henderson found that on average, in a six year period, around 13 percent of employed women started providing unpaid care out of those who were not providing any care work previously. Examining the effects of different workplace policies on the implications of care work for women, they revealed that, in general, women are at greater risk of leaving the labor workforce if they take on unpaid care work. However, they observed that women who had access to flexible working policies in their workplace were more likely to stay in employment. An interesting finding was that such association was observed among all women employed who had access to such policies, regardless of their caring responsibilities. This study highlights the importance of supportive workplace policies for women to continue their labor force participation. Also in the United States, research on employed women who provide care for older people, found that women who received instrumental support, such as physical assistance, from their partners were better able to balance their roles (Franks and Stephens, 1996).

How women balance their multiple roles depends on a number of interacting factors. Some are at the individual level and others are more related to the community surrounding them and underpinning support from government policies. However, flexible work environments and the availability of supportive

workplace policies are crucial to enhancing women's participation in the labor force. The relatively low prevalence of women who combine family, care and employment responsibilities in the United Kingdom and North America (Rosenthal 1997; Spitze and Logan; 1990; Evandrou and Glaser 2004) indicates the extent of the barriers faced by women who are seeking to balance their multiple roles. In the United Kingdom, Himmelweit and Land (2008) regarded the situation to be unsustainable and called for swift improvement in types and quality of support and working opportunities available to informal carers so everyone can combine both. Similar findings regarding the difficulties in combining informal care and employment, particularly among women who provide high levels of support, were found in a study of 11 European countries (Bolin et al 2008). However, the same study reported variations across countries, related to formal institutional arrangements and policies as well as informal norms and culture. Policies enabling more flexible working hours and provision of paid leave were particularly important. The availability of informal support to women to 'care share' through partners, older children, friends or other members of the community is also fundamental in facilitating women's participation in the labor force.

7. Policy options enabling women to balance multiple roles of labor participation and informal care

While Russia faces some population trends that are particular, many countries have made efforts to sustain family carers in their roles and some attempt to support carers within the labor force or to enable carers to rejoin employment if the need for their care declines or finishes. Other policies not considered here in detail relate to public health policies to reduce the need for care among older people and to prevent the development of long-term health conditions. These may impact on women in particular.

Governments face growing expectations to provide and maintain high quality long-term care, the demand for which is escalating. This goes hand in hand with an increasing need to maximize participation in the labor market including that of women who have been the traditional providers of informal care. Therefore, this gives rise to expectations that governments should adopt sensible and cost-effective policies that aim to maximize the opportunities for women to balance their formal labor participation as well as provide, in partnership with men, much needed support and care to supplement that provided by the government. Among most developed countries, there is a trend towards more universal public provision or underpinning of long-term care services. However, most policies promoting work life balance are usually designed around child-care provision and maternity or in some cases paternal leave.

The impact of informal care and labor force participation is becoming increasingly important due to several factors including the reality of increased demand for both long-term care and labor participation. A volume of empirical research indicates the difficulties associated with combining care and work responsibilities, particularly caring for older people when compared to childcare. Unlike the care of children, which follows a fairly predictable time schedule, care for older or disabled people is unpredictable in duration and intensity, also it may increase in intensity over the course of the care experience. Moreover, there are very limited formal substitutes for informal care provided by the family, most often women. Studies from the United Kingdom, mainland Europe and the United States, all indicate that when informal caring responsibilities increase then labor force participation decreases, particularly among women (Carmichael and Charles, 1998; Wolf and Soldo 1994; Bolin et al 2008; Crespo 2006). In Australia Watts (2008) found that providing care for a partner had the greatest negative impact on the labor participation of women, followed by friend, son or daughter, then a parent.

There are several government approaches that address, and seek to improve, work-life balance in general but rarely with a clear focus on providing care to older people. As mentioned earlier, the majority of policy focus relate to the care of young children, with very little attention to employees who care for older or disabled people. Relating to general work-life strategies, three major types of approaches emerge from the literature. First, some countries such as the United

Kingdom, New Zealand and Australia have developed ***campaigns to promote work-life balance*** in the workplace by targeting employers. The second can be found in the Netherlands, Sweden and Denmark where efforts to support workers to balance work and other responsibilities, include caring for older people, have been developed through ***a broad range of measures***. The third group, such as France, Belgium, United States and Ireland, focus on ***developing legislation and initiatives*** supporting work-life balance.

In the first group, a business case is usually presented to promote the value of work-life balance. Employers are encouraged to recognize that available coping mechanisms will increase workers' productivity. Initiatives are usually based in providing information on websites or newsletters on the importance of improving work-life balance. These also provide workers with links to organizations that provide information and support to carers, people with disabilities and others. However, compliance with these guidelines is voluntary with the exception, in the UK, that parents, of children under six years or disabled children under 18 years, have had the right to request flexible working arrangements (from April 2003) and this is now being extended to other age groups. In New Zealand, a Work-Life Balance Project has been established since 2002 to provide information aimed mainly at parents, similar resources are available in Australia to inform carers of relevant legislation.

Examples of work-life balance policies

The ***Netherlands, Denmark and Sweden*** have developed policies and legislation to support workers' ability to balance work with other responsibilities, with a prime focus on caring for older people. In these countries there are long standing policies in regard to equal opportunities policies for men and women. Compared with other developed countries, gender gaps in employment in the three countries are relatively small; this is despite the fact that women are the major provider of unpaid care.

Dutch policy approaches include a right to adjust working time, parental and other leave to care for family members, and a policy initiative to make it easier for people to combine work and care and to help older workers continue working as long as possible. The Adjustment of Hours Law (2000) gives workers in the Netherlands the right to request a change in their normal working hours, without necessarily providing an explicit reason to employers. Since the implementation of this law, the rate of part-time employment has increased. Another law, the Equal Treatment of Working Hours Act (1996), protects part-time workers from discrimination relating to equal access to training and promotion opportunities. The Work and Care Act (2001) encompassed provisions for different types of leave to care for children and other relatives, while the Paid Employment and Care Act entitle workers to receive 70 percent of minimum wages for a period of six week full-time care leave (European Commission 2003). The majority of work-life balance policies in Denmark and Sweden are centered on promoting women's and men's participation in the labor force through measures addressing child-care.

Women in Japan traditionally have not had access to high-skill job opportunities that can provide them with flexibility if they need childcare. However, between 1987 and 1997, the share of part-time employment increased from 14 percent to 19 percent. This may be linked to Japanese tax policy, which encouraged married women to work part time by exempting, within a certain income range, part time workers' earnings from income and social insurance taxes (Japanese Statistics Bureau 1998; <http://www.stat.go.jp/english/data>).

Appelbaum and colleagues (2002) provide some examples of strategies adopted by employers and workers in the developed world to balance care and work responsibilities. One example was an Australian law firm where 60 percent of their lawyers were women, despite the traditional long working hours of attorneys. The firm has adopted a 'working at home' policy which allows staff to work at least one day a week at home, while the firm provides them with equipment, such as laptops, cell phones and others, for effective work at home. Despite the higher overheads in implementing this strategy, and sometime complaints from clients, management believed the arrangement pays off in higher productivity and reducing staff turnover. Another example was observed in the Netherlands, where an elder care facility (care home) offers employees a balance between work and family that is not typical for residential homes and it pays a similar hourly rate to both full and part time workers.

One of the main dilemmas facing women who provide informal care when negotiating participating in the labor force is the availability of someone else to take over the care responsibility while working, even if part time. As discussed in Section 8, some countries provide care breaks or other forms of flexibility in employment for women. As noted earlier, one of the main options for women to balance their multiple responsibilities is part time work and job sharing. However, an important issue is the recognition that women opt for these arrangements from practical need and not by choice and they may need to enter the labor force on a more full time basis later in their lives. For part-time, or other flexible working arrangements, to be successful employers should provide opportunities for training, promotion and career progression to avoid marginalizing these staff.

In the Netherlands under the Adjustment of Hours Act some companies have introduced job sharing to allow employees to benefit from the provisions of this law (Appelbaum et al 2002). Employees who job-share typically work alternating two or three-day weeks. Such options have been promoted among skilled employees in law firms, and with managers and medical staff in hospitals, making it possible that part time work does not necessarily mean taking up low skilled jobs.

Another temporary option available in some countries is that women, or other carers, can take some paid time off if they are full-time workers. Duration of paid leave varies dramatically by country from two weeks per year in Japan to four weeks in Australia and five to six weeks in Germany and Sweden respectively. In all these countries, except Germany, such paid leave is legally guaranteed. For

part time workers the number of days leave is usually *pro-rata*. In the United States, however, companies are not required to provide paid leave.

Some countries, such as the Netherlands, have reduced the working week from 40 to 36 hours. Alternatively, some companies in Germany and Japan have introduced 'working-time' accounts where employees schedule their working hours across the week to suit their circumstances best. In some companies, in Italy and Germany, hours-per-week may be averaged over several weeks, meaning that an employee can work more days one week and less in others (Appelbaum et al 2002).

From the review and discussions in Sections 6 and 7 it is evident that for women to be able to combine their growing caring responsibilities and labor force participation depends on a mixture of state policies, individual circumstances and cultural factors, including both family and work cultures. Flexible work opportunities and 'care share' support are crucial elements in this mixture. Whilst increasing numbers of countries are exploring and introducing different policies aimed at supporting work-life balance, there remain huge differences between the level and nature of policies.

8. Examples of policy options providing financial support for informal caregivers

This final section provides examples of policy initiatives from a range of countries facing aging populations and demands for long-term care. These may be seen as ‘support for the supporters’, rather than efforts to replace women’s informal care by state or market services. Services that have traditionally provide care to people without family carers are now seen as potentially useful to carers. In the light of Russia’s demographic trends such policies may be worth considering and all policies should assess the impact on women of their outcomes.

As discussed in the previous sections, informal carers play a crucial role in providing long-term care for older people. In addition, there is a growing shift to provide care in the community and to maintain older people in their homes where possible, where people may receive a combination of formal and informal care. This objective has been termed ‘aging in place’. There is an observed trend of people ‘aging in place’ in most OECD countries, despite the predicted decline in informal care by family members in developed countries. However, there is a substantial variation over time and across different countries in policies affecting LTC (Anderson and Hussey 2000, Organization for Economic Cooperation and Development (OECD) 2003; OECD 2005).

Moreover, a number of countries have taken steps to make more intensive home care available as an alternative to institutionalization in hospitals or nursing homes. Australia has for some years provided *Community Aged Care Packages* as a community alternative for frail older people whose dependency and complex care needs would qualify them for entry to a care home. Sweden and the United Kingdom have both developed a more targeted approach to publicly funded home care, where more hours of care are provided but to fewer, more disabled people. Austria, Germany, Japan and Luxembourg have introduced in recent years schemes dedicated for older people with disabilities at home. In Austria, this is in the form of cash payments, in Japan in the form of service provision, while Germany and Luxembourg offer a choice between cash benefits and in-kind services.

Family and friends, in particularly women, share the responsibility of care, not only through providing informal care but also by making substantial co-payments to LTC programs provided under public programs. The payments schemes described above are in part intended to support family carers. For example, the availability of a family carer is a condition of the Australian Extended Aged Care at Home packages.

Many countries acknowledge the role of informal care particularly in relation to home based LTC and have initiatives to support family carers, even though home care services have usually been developed to provide help to people when family

carers are not available. Most home care services were initially provided to help older people living fairly independently on their own with the aim of delaying or preventing a move into a nursing or care home. This is still the case in some countries such as South Korea, Mexico and Spain that have limited home care services. However, in many other countries the growing evidence of carer burden (distress and poor quality of life) added a welfare and equality argument to provide more services to support carers. A number of policies have been adopted as countries seek to support family carers' efforts. Australia, England and the United States, have published ***national strategies*** setting out the needs of carers and the role of various services in providing support. In England carers have a statutory right to receive an assessment of their need for services in addition to services for people they are supporting. Many countries have introduced respite-care or short break services to provide carers with a break from their caring responsibilities, however these depend on assessments and local resources. Some states, such as Germany and the United Kingdom, give ***pension credits*** to enable those out of the labor market due to caring to maintain pension rights. Several countries including Australia, Canada, Ireland, Sweden and the United Kingdom have introduced payments to carers to compensate for lost employment income due to caring, however, these are usually limited.

Respite care is one of the most important services for carers, which can take the form of day care or short-term residential care (Moïse et al., 2004). Provision of respite care has seen significant growth in many developed countries in recent years. Australia, for example, quadrupled expenditure on respite care between 1996-97 and 2002-02, and Germany has introduced a right to four weeks of respite for carers of severely disabled persons as part of LTC insurance. However, potential demand for respite care remains considerably higher than provision in most countries. Moreover, most services to carers are being expanded from a low base, meaning there is a long way to go before meeting the needs and compensating for the full efforts of informal carers.

Some countries provide some form of ***financial benefits*** to informal carers as income support. In Australia, a Carer Payment is offered for people who cannot support themselves through employment because of caring responsibilities, in addition there is a Carer Allowance for people who live with and care for somebody at home. In Ireland both Carer's Allowance and Carer's Benefit are in place. A Carer's Allowance is for carers with a low income who live with and look after people needing full time care while a Carer's Benefit is a payment to insured persons leaving work temporarily to care for someone needing full time care. More recently, Japan has introduced an Allowance for Families Caring for the Elderly for low-income families with heavy care needs and not receiving support from the long-term care insurance, however, this scheme plays a limited role in the overall LTC provision. Sweden has the highest provision for carers where 80 percent of normal employment income is paid under Care Leave, which is a statutory right to take leave from work for up to 60 days when caring for a terminally ill relative. In the UK, a Carer's Allowance is available for low-income persons of working age caring for 35 or more hours per week and Attendance Allowances are available to all eligible disabled people to enable them to pay for care and associated expenses.

Although these examples illustrate how a number of countries make various forms of payments to informal carers, these are not meant to fully compensate carers for the value of their work but to sustain a minimum level of income. Therefore, some of the schemes are only available to low-income carers. Moreover, to be eligible for support, income criteria may also take into account the income of a carer's spouse or partner and they therefore exclude carers from middle or high-income families. Some schemes are built into labor market institutions and provide an option for temporary leave from work, such as those in Canada and Sweden. However, there are some schemes that are meant to reward the work of informal carers for people with less severe needs, for example the Australian Carer Allowance, eligibility for which is conditional only on the provision of care and not on a carer's income.

The economic rationale for 'paying' or reimbursing informal carers depends much on their labor market attachment. For people who would otherwise be employed, payments for informal care, such as within a leave scheme, represent an insurance against the loss of employment income they incur while providing care. Such payments allow families or individuals to choose informal care, and to the extent that such care replaces more expensive care that would have been provided formally and publicly funded, the effect on public finances may be positive. Much, however, depends on the labor market impacts. Particularly for those with a loose attachment to the labor market, a prolonged period of leave can lead to subsequent long-term unemployment because their skills or human capital may gradually deteriorate. Women in their 50s taking leave to care for a parent or parent-in-law may frequently be at high risk in this regard. High payments to informal caregivers may therefore produce an unemployment or low-income trap by reducing the incentive for lower-skilled caregivers to retain contact with the labor market. Active assistance to help long-term caregivers to find paid employment when caring ceases, together with a carer-friendly work culture, will be important measures if the dual goals of supporting carers and maintaining employment in older age groups are to be achieved.

Schemes providing short-term cash support to carers, e.g., during terminal illness, avoid these longer-term effects. An example is the new Compassionate Care Benefit in Canada, mentioned above, which provides short-term help for carers and enables them to stay in their jobs in the longer term, with a protected return to work. Ireland also provides a Carer's Benefit to enable a carer to be supported during a temporary period of absence from work.

For people who are outside employment and have other income, such as retired persons having a pension, caregiving does not entail an income loss (in theory) and therefore there is no insurance argument for compensating them for loss of income. However, to limit the need for costly formal long-term care services, many countries actively seek to mobilize and recognize informal caregivers for their work, particularly by providing direct help for them. This includes support in terms of training for informal care-givers, respite care and in some countries payments for all informal carers satisfying basic criteria and disregarding their labor market attachment and other income.

The Australian system introduced choice by enabling those family carers who wish to do so to provide informal care, while receiving a Carer Payment to compensate for loss of employment income. This option has been taken up by a small, if growing, number of people, rising from 11,740 recipients caring for those aged 65 and over in June 1998 to 18,097 in June 2002. However, in Sweden the number of people taking a similar option via the Attendance Allowance has declined to 4,980 in 2001 from 20,000 a decade previously. In this country, the current policy direction is to focus resources for carers on non-financial help through the development of respite care, counseling and personal support for carers. Australia has a federal structure in which the Australian (central) Government deals with national concerns such as foreign policy, social security and major forms of taxation, and State/Territory governments cover areas such as education, public housing and hospitals. The provision of LTC 'aged care' involves both tiers of government, with care being provided by a range of public and private (profit and non-profit) providers.

The Irish Government's policy is to maintain older people independently at home when they wish, and to provide care in hospital and care homes when they can no longer be maintained at home. The public health system provides both residential and community services, but an independent review of long-term care funding in 2003 argued that current funding arrangements favor residential care and proposed a new social insurance scheme for long-term care, to be supplemented by voluntary insurance (Mercer Limited, 2003).

In Russia since 1999, some support has been ensured by the Russian Federation Labor Code for employees taking care of sick family members subject to medical certification. Such support is limited to some forms of flexible working conditions, such as being engaged in night work only by consent and not having to do overtime or being sent on business trips without their consent. There are also some pension benefits for carers, which have been in effect from 1991 under the RSFSR law.

Examples of coping mechanisms and how women balance work and LTC provision

As explained in Section 7, most existing work-life balance or 'family friendly' policies and services are primarily designed for parents of young children and rarely address the needs of employees who care for older or disabled people. The issue of work-life balance is receiving variable attention in different countries. Some countries, such as the United Kingdom, New Zealand and Australia, support work-life balance as an explicit policy goal. Various campaigns focus on encouraging the voluntary agreement of employers to develop and implement policies and practices supporting a work-life balance in their organizations. Some countries, such as the Netherlands, Denmark and Sweden, focus on developing legislative and social policy goals to support workers who provide unpaid care including those providing care for older people. Netherlands' 'leave savings' and Sweden's sabbatical leave, allow workers more time to devote to caring responsibilities.

The resulting situation, in many countries, is that women or other carers who are faced with caring responsibilities for older people either quit working or opt for part time work which may underuse their skills and education (Swanberg 2006; Marler and Moen 2005). Many women carers find one of the only options available is to work fewer hours, however, most highly paid workplaces lack flexible work arrangements (Todd 2004). In Australia, one-third of employees providing informal care indicated that due to their caring responsibilities they had to work fewer hours, take periods of unpaid leave or take jobs with less responsibilities which required fewer skills than they held and 13 percent refused promotions from the fear of increased responsibilities (Morehead et al 1997).

Research also shows that a large percentage of those caring for younger children are also caring for older relatives (Families and Work Institute 1998; Krouse and Afifi 2007). Women who have multiple caring and work roles usually have bi-directional stress spillover between work and family (Allen et al 2000; Edwards and Rothbard 2000). Stress is particularly evident when women combine their informal caring responsibility with a career of formal care provision due to high emotional involvement at work and home (Brody, 1985; Pearlin et al, 1990; Hochschild, 1983; Krouse and Afifi 2007). Moreover, societies usually devalue formal care provided by women due to the proximity of caring work with female roles as mothers or wives (England and Folbre 1999).

A qualitative study in New Zealand, conducted by the Department of Labour (2003), showed that managing work and family caring responsibilities was a complex activity. This is a particular issue when work-life balance is needed due to forced circumstances, applying to many informal women carers, which are exacerbated further when their role as informal carers is not valued by society. Canadian research indicated that many supporting mechanisms of work-life balance rely on unwritten policies of supportive managers and co-workers (Higgins and Duxbury 2005). The same research found that the majority of Canadian employees have difficulty balancing work and family responsibilities due to issues related to workplace environment and unsupportive managers.

Conclusion and Recommendations

This report has outlined important demographic trends within Russia, in order to assess women's participation in the labor force and how this may be affected by the increasing demand for long-term care. The findings confirm the crucial role of Russian women in providing both formal and informal long-term care. The need for long-term care is undisputed and short-term measures, such as migration, are highly unlikely to compensate for population losses or to be able to provide care for the aging population.

Population projections uniformly confirm the likely rise in numbers and proportions of the older population in Russia. The remarkable gender gap in life expectancy is highlighted. Low fertility and early male mortality rates are further important demographic challenges within Russia. Regional differences in life expectancy are also sizeable and data on these would be valuable for developing regional and local responses to the predictable shortages of long-term care. However, changes in family patterns, lower fertility rates, high divorce and high widowhood rates are nationwide and expose the risks of relying on female informal care to support people in later life. Women are facing particular challenges within these changes as both the main provider and receiver of care in their old age. Moreover, population projections show that the potential labor supply is unlikely to meet the needs of the economy as well as the need for care among growing older age groups. On the one hand, policies might raise the rates of labor force participation among older age groups to address labor force shortages. On the other hand this may lead to shortages of care for older populations and further demand for public provision funded out of taxation. The dual challenge is to ensure that additional years of later life are lived in good health to reduce demand for long-term care and to provide good quality of life for both carers and older age groups so that female labor participation rates are maximized without undue stress for women.

Russia's historical context of high levels of female labor participation rested on a tradition of official support for working women. This may be built up again in different formats and with a new set of values that recognize gender equality is not simply a matter of labor force participation but has to extend to women's rights within families and communities for equal treatment and opportunities. It is the case that there is a potential underused female labor force in Russia. The decline in employment among older people of both genders in Russia is also noted. From the different projections and scenarios presented in this report, it is apparent that Russia needs to make the most of its whole population, in terms of maximising labor participation rates for both men and women and for those in different age groups, particularly 'older' workers, whether this is part time or full time.

As in other countries, the majority of long-term care is provided informally by women for their family members in Russia. Formal care provision is increasing for older people; however, there are wide geographical variations. The interaction of formal care with informal care in Russia is unknown, particularly

the ways in which formal care may support carers in employment. Examples of the cost-effectiveness and good practice in this area would be welcome. Financial and labor market policies for aging populations in other countries have been targeting women in the mid life age group to encourage labor market participation. Efforts in a Russian context should be evaluated.

Across the globe, countries are facing the challenges of aging populations and need to combine long-term care efforts from informal carers and formal services. Many developed countries increasingly prioritize home-care services rather than institutional care. Many also provide a range of financial incentives or compensations for family members providing care. The cost-effectiveness of this in Russia should be explored.

Women in Russia and elsewhere juggle work and caring. Policies enabling more flexible working hours and provision of paid leave may enable them to manage both roles. But they also need to be able to share their caring responsibilities with partners, older children, friends or other members of the community. Education and public information may help promote such responsibilities.

While Russia faces some population trends that are particular to this country, family carers can be better sustained in their roles. Public support for carers within the labor force may need to be made explicit and measures to enable carers to rejoin the labor force may need encouragement or legislative backing. Other policies options relate to public health initiatives to reduce the need for care among older people and to prevent the development of long-term health conditions.

There is no shortage of policy initiatives from a range of countries facing aging populations and demands for long-term care. In essence, strategies now tend towards 'support for the supporters', rather than efforts to replace women's informal care by state or market services. Services that have traditionally provided care to people without family carers may be also potentially useful to carers. In the light of Russia's demographic trends such policies may be worth considering and all policies should assess the impact on women of their outcomes.

Recommendations:

Based on the analysis and discussion in this report we recommend the following:

- It is paramount for Russia to explore ways to maximize both male and female labor force participation including older age groups that do not reduce the quality of life of carers or people receiving their support.
- Governments should explore the effectiveness of different policies that aim to assist women to seek and gain training to improve the quality of jobs available to them both in terms of finding jobs for first time and to regain employment after breaks from employment.
- Policy makers should consider the availability of such training and employment support to promote flexible working to allow women to balance their multiple roles.

- Similarly, employment policies and workplace strategies should be explored to support workers, particularly women, to combine multiple caring and labor force roles.
- Governments should explore and adopt family policies aimed at supporting carers, particularly those caring for older people, to facilitate maintaining some labor force participation while offering informal care and regaining full participation when caring responsibilities finish.
- Policy makers should acknowledge existing wide geographical variations when adopting and implementing different policies and seek to provide equality of opportunity and support.
- Governments should engage with carers' organizations and develop their capacity to learn from the experiences of carers to influence policy and employment practices.

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